

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-151(4)  
30M REV 3/768

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|  |  |  |  |   |  |   |  |   |  |                               |  |
|--|--|--|--|---|--|---|--|---|--|-------------------------------|--|
| 05163  |  | 05167  |  |   |  |   |  |   |  |                               |  |
| 1. DECEASED-NAME<br>(Type or print) Naomi SPEICE   |  | First Middle Last Abbott   |  | 2a. DATE OF DEATH<br>Month 4- Day 3 Year 68   |  | 2b. HOUR<br>6:30AM  |  |   |  |                               |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>5-12-97   |  | 6. AGE (In years last birthday)<br>70 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                      |  | IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br>OHIO  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE Md.   |  |   |  |                               |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore CO.   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If at home, give street address)<br>HILLDALE 6615 ELSMERE PL. APTS. |  | 12a. USUAL OCCUPATION (Kind of work done during week preceding death, when if retired.)<br>HOUSEWIFE  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MD.   |  | 13b. COUNTY<br>BALTO.  |  | 13c. CITY OR TOWN<br>BALTO.CO.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>21234 6615 ELSMERE PLACE. |  |                               |  |
| 14. FATHER'S NAME First Middle Last<br>WILLIAM C. SPEICE   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>UNK.  |  |   |  |   |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) NO  |  | 16b. SOCIAL SECURITY NO.<br>017-26-8329 B  |  | 17. INFORMANT<br>WM E. ABBOTT   |  | Address<br>AS IN 13 a-b-c-e   |  |   |  |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebrovascular accident<br>4369 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. atherosclerosis<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) years<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 minutes |  |  |  |   |  |   |  |   |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>331X Congestive heart failure  |  |  |  |   |  |   |  |   |  |                               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |  |                               |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |                               |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County  |  | State                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept, 1963, to April, 1968, that (I) (we) last saw the deceased alive on 3/27/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |   |  |                               |  |
| 22b. SIGNATURE<br>J. F. Palmisano MD   |  |  |  | DEGREE<br>ATTENDING PHYS.   |  | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.          |  | 22c. DATE SIGNED<br>4-3-68                          |  |                               |  |
| 22d. PHYSICIAN'S NAME (Type)<br>J. F. Palmisano, M. D.   |  |  |  | 22e. ADDRESS<br>6608 Loch Raven Blvd. Balto. 21212  |  |   |  |   |  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>CREMATION   |  | 23b. DATE<br>APRIL 3, 68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GREENMOUNT CRE.   |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MD.                                 |  |   |  |                               |  |
| 24. FUNERAL DIRECTOR<br>W. Brooks Bradley  |  |  |  | ADDRESS<br>DUNDALK, MD.   |  | 25a. REC'D BY REGISTRAR<br>APR 5 - 1968   |  | REGISTERED SIGNATURE<br>Charles Judge               |  |                               |  |

03150



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 21a-21f film 399  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05164

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05168

|  |   |  |  |   |  |  |  |   |
|--|---|--|--|---|--|--|--|---|
| 1. DECEASED-NAME<br>(Type or Print)<br><b>Douglas Edward Ahrens</b>  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> Month <b>April</b> Day <b>11</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>10:30 PM</b>  |  |   |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br><b>12/18/1951</b>                    | 6. AGE (In years last birthday)<br><b>16</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b>                    | 2c. DATE PRONOUNCED DEAD<br>Month <b>April</b> Day <b>11</b> Year <b>1968</b>  |  |   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore Md.</b>   |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph's Hosp.</b>                  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Student - Northern High Sch</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |   |  | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>12</b>                                     | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>                       | 13e. STREET AND NUMBER<br><b>1254 Meridene Drive</b> |   |
| 14. FATHER'S NAME<br>First <b>Richard</b> Middle <b>B.</b> Last <b>Ahrens</b>  |   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Gloria</b> Middle <b>P.</b> Last <b>Ansel</b>   |   |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |   |  | 16b. SOCIAL SECURITY NO.<br><b>818.9</b>   |   | 17. INFORMANT<br><b>Richard B. Ahrens</b> ADDRESS<br><b>(Same)</b> |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Crushing Injury of Skull</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |   |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>8244</b>   |   |  |  |   |  |  |  |   |
| 19a. DATE OF OPERATION<br><b>4-11-68</b>   |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |   | 21b. TIME OF INJURY Month, Day, Year<br><b>4-11 1968</b> |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Thrown from auto which rolled on his head</b>                         |  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Street</b> |  | 21f. LOCATION Street or R.F.D. No.<br><b>Phoenix</b>   |   | City or Town<br><b>Baltimore</b>                                   | County<br><b>Md</b>  | State  |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |  |   |  |  |  |   |
| ACTUAL SIGNATURE<br><b>Charles F. O'Donnell</b>  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |  | 22b. DATE SIGNED<br><b>April 11, 1968</b>  |  |   |
| EXAMINER'S NAME (Type)<br><b>Charles F. O'Donnell</b>  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |  | ADDRESS (Street, city, town, or county)  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |   | 23b. DATE<br><b>4/15/68</b>                              | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem. Grds. Timonium, Balto. Co. Md.</b>                            |   |  | 23d. LOCATION (City or Town) (County) (State)  |  |   |
| 24. FUNERAL DIRECTOR<br><b>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>   |   |  | 25a. REC'D BY REGISTRAR<br><b>APR 16 1968</b>  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |





05163

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 13 Film G399 4/10/68 kk

## CERTIFICATE OF DEATH

05169

|   |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Tekla</b>   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>4-2-68</b>  |  |  | 2b. HOUR<br>M  |  |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>W</b>  |  |  | 5. DATE OF BIRTH<br><b>Jan. 5, 1904</b>   |  |  | 6. AGE (In years<br>lost birthday)<br><b>64</b> YRS.                                 |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Latvia</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Balto.</b> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mt. Wilson</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Mt. Wilson Hosp.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>None</b>   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission). STATE<br><b>Mt. Wilson, Md.</b>   |  |  | 13b. COUNTY<br><b>Balto.</b>   |  |  | 13c. CITY OR TOWN<br><b>Mt. Wilson</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br><b>Jekabs Ivans</b>  |  |  | First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Alvine Kimenis</b>   |  |  | First Middle Last  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>  |  |  | 17. INFORMANT<br><b>Dr. Valdis, Mt. Wilson, Md. 21112</b>   |  |  | Address  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br><b>4120</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) <b>Nephrosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>9 mos</b>                      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>443 Hypertensive arteriosclerotic cardiovascular disease</b>  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?              |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                            |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/4</b> , 19 <b>67</b> , to <b>4/2</b> , 19 <b>68</b> , that (I) (we) last<br>saw the deceased alive on <b>3/7</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.            |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Alfred Ossman</b>  |  |  |  |  |  | 22c. DATE SIGNED<br><b>4-2-68</b>   |  |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>Alfred Ossman</b>  |  |  |  |  |  | 22e. ADDRESS<br><b>1101 St. Paul St., Balto., Md.</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Cremation</b>  |  |  | 23b. DATE<br><b>4-4-68</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto., Md.</b>                  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Witzke Funeral Directors, Balto., Md. 21229</b>  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 04 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 05166  |  | MAY 1968  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  | 05170   |  |
| Item 1 Film G399 4/26/68 Kk  |  |   |  |   |  | CERTIFICATE OF DEATH  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br>WILLIAM  |  | Middle<br>F. S.   |  | Last<br>AMRHINE   |  |
| 2a. DATE OF DEATH  |  | Month<br>4/17/68  |  | Day<br>Month  |  | Year<br>Year  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>Dec. 5, 1889  |  | 6. AGE (In years<br>last birthday)<br>78 YRS.   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Caton Ridge Nursing Home |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Retired Carpenter   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Parkville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME First<br>Charles   |  | Middle<br>H   |  | Last<br>Amrhine   |  | 15. MOTHER'S MAIDEN NAME First<br>Emma  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) No  |  | 16b. SOCIAL SECURITY NO.<br>212-10-6407   |  | 17. INFORMANT<br>Mr Kenneth W Amrhine   |  | Address<br>1210 Havenwood Rd  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ① Bronchopneumonia<br>440.9 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ② (b) Generalized Arteriosclerosis & Chronic<br>DUE TO, OR AS A CONSEQUENCE OF (c) Brain Syndrome |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4500   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                             |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-21-1967, to 4-17-1968, that (I) (we) last saw the deceased alive on 4-17-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Cesar Valle Caverio  |  | DEGREE<br>M.D.  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br>4-18-68   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>CESAR VALLE CAVERIO  |  | 22e. ADDRESS<br>3629 Liberty Rd.  |  |   |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>4/20/68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial Pk  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |  |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck Inc. Baltimore Md. 21214   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE APR 22 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 05167  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 05171  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|-----|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| ADELAIDE   |  |  |  |  |  |  |  |  |  | April 23 1968  |  |  |  |  |  |  |  |  |  | 5:15PM   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)                                      |  |  |  |  |  |  |  |  |  | 7. IF UNDER 1 YEAR                           |  |  |  |  |  |  |  |  |  | 8. IF UNDER 24 HRS. |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| Female   |  |  |  |  |  |  |  |  |  | White  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 42 YRS.  |  |  |  |  |  |  |  |  |  | MONTHS                                       |  |  |  |  |  |  |  |  |  | DAYS                |  |  |  |  |  |  |  |  |  | HOURS |  |  |  |  |  |  |  |  |  | MIN |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| Kentucky   |  |  |  |  |  |  |  |  |  | USA  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |  |  |  |  |  | Md.  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 1d. CITY OR TOWN OF DEATH  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| Baltimore, Maryland  |  |  |  |  |  |  |  |  |  | Greater Balto. Med. Cen.   |  |  |  |  |  |  |  |  |  | Housewife  |  |  |  |  |  |  |  |  |  | Home   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?   |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER                       |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| Maryland   |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 24 Summit Avenue                             |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| Harry A. Macbrair  |  |  |  |  |  |  |  |  |  | Elizabeth M Parrott  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | Address  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| No   |  |  |  |  |  |  |  |  |  | 403 26 1145  |  |  |  |  |  |  |  |  |  | Mrs. Dorothy K. Davis  |  |  |  |  |  |  |  |  |  | 44 Windmoor Place.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  | 19. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale and respiratory insufficiency   |  |  |  |  |  |  |  |  |  | 1965   |  |  |  |  |  |  |  |  |  | Osteosarcoma   |  |  |  |  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | Yes  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary metastases  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Osteogenic sarcoma of right knee  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 199.2 Amputation right leg   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  |  |  |  |  |  | 21f. LOCATION  |  |  |  |  |  |  |  |  |  | Street or R.F.D. No.   |  |  |  |  |  |  |  |  |  | City or Town                                 |  |  |  |  |  |  |  |  |  | County              |  |  |  |  |  |  |  |  |  | State |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 26, 1968, to April 23, 1968, that (I) (we) last saw the deceased alive on April 23, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| John E. Adams  |  |  |  |  |  |  |  |  |  | April 23, 1968   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| JOHN E. ADAMS, M.D.  |  |  |  |  |  |  |  |  |  | Greater Baltimore Medical Center   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REINTERMENT  |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town)   |  |  |  |  |  |  |  |  |  | (County)                                     |  |  |  |  |  |  |  |  |  | (State)             |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| Buried   |  |  |  |  |  |  |  |  |  | 4-26-68  |  |  |  |  |  |  |  |  |  | Lake View Mem.Pk. Cem.   |  |  |  |  |  |  |  |  |  | Balto. Co. Maryland  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |
| Wm. E. Johnson   |  |  |  |  |  |  |  |  |  | 8521 Loch Raven Blvd. Balto. 21204   |  |  |  |  |  |  |  |  |  | APR 26 1968  |  |  |  |  |  |  |  |  |  | Charles Judge  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |     |  |  |  |  |  |  |  |  |  |

UNITED STATES OF AMERICA

IN SENATE  
 January 1, 1918  
 REPORT  
 OF THE  
 SECRETARY OF THE INTERIOR  
 CONCERNING THE  
 LANDS BELONGING TO THE UNITED STATES  
 IN THE TERRITORY OF ARIZONA  
 BY  
 JAMES H. HAYES, SECRETARY OF THE INTERIOR

*James H. Hayes*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| 05168  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 05172                           |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------------------|--|--|--|--|----------------------------|--|--|--|--|------------------|--|--|--|--|-------|--|--|--|--|-----|--|--|--|--|
| 1. DECEASED-NAME (Type or print)   |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH               |  |  |  |  |                            |  |  |  |  | 2b. HOUR         |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| Martin   |  |  |  |  |  |  |  |  |  | APPLEBAUM  |  |  |  |  |  |  |  |  |  | April Month 29 Day Year 68      |  |  |  |  |                            |  |  |  |  | 9:50 A M         |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 3. SEX   |  |  |  |  | 4. RACE  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday) |  |  |  |  | IF UNDER 1 YEAR            |  |  |  |  | IF UNDER 24 HRS. |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| Male   |  |  |  |  | White  |  |  |  |  | August 2, 1923   |  |  |  |  |  |  |  |  |  | 44 YRS.                         |  |  |  |  | MONTHS                     |  |  |  |  | DAYS             |  |  |  |  | HOURS |  |  |  |  | MIN |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |                                 |  |  |  |  | Md.                        |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| Baltimore  |  |  |  |  | USA  |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| Baltimore  |  |  |  |  | St. Joseph Hospital  |  |  |  |  | Court Reporter   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER          |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| Maryland   |  |  |  |  | BALTO  |  |  |  |  | Baltimore  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  |  |  |  | 24 Maryland Avenue #21208       |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  | First Middle Last  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  | First Middle Last  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| ELLIS  |  |  |  |  | APPLEBAUM  |  |  |  |  | REBECCA  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT  |  |  |  |  | Address  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| YES  |  |  |  |  | WILL   |  |  |  |  |  |  |  |  |  | MRS FLORENE APPLEBAUM  |  |  |  |  | SAME                            |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| IMMEDIATE CAUSE (a) Acute Myocardial infarction  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |  |  | (b) DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | (c)  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 4201   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-26, 19 68, to 4-29, 19 68, that (I) (we) last saw the deceased alive on 4-29, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| Elmo Gayoso, M.D.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 4-29-68  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | 7620 York Road, Baltimore, Md. 21204   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| Burial   |  |  |  |  | 4/30/68  |  |  |  |  | Crimm Memorial City Chm  |  |  |  |  | Baltimore Md   |  |  |  |  |                                 |  |  |  |  |                            |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR         |  |  |  |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |
| Sydney S. Lewis & Son, INC   |  |  |  |  |  |  |  |  |  | 9610 Reisterstown Rd   |  |  |  |  |  |  |  |  |  | DATE APR 30 1968                |  |  |  |  | Charles Judge              |  |  |  |  |                  |  |  |  |  |       |  |  |  |  |     |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05168

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05173

|   |         |  |                  |   |                                     |  |   |                        |
|---|---------|--|------------------|---|-------------------------------------|--|---|------------------------|
| 1. DECEASED-NAME<br>(Type or print)   |         | First  | Middle           | Last  | 2a. DATE OF DEATH<br>Month Day Year |  | 2b. HOUR<br>8 <sup>30</sup> AM            |                        |
| Thelma  |         | Eleanor  | Armiger          | April 22, 1968  |                                     |  |   |                        |
| 3. SEX  | 4. RACE |  | 5. DATE OF BIRTH |   | 6. AGE (In years last birthday)     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |                        |
| Female  | White   |  | 1 Sept. 1910     |   | 57 YRS.                             |  |   |                        |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. COUNTY OF DEATH   |   |                        |
| Maryland  |         | USA  |                  |   |                                     | Baltimore Md.  |   |                        |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                     | 12b. KIND OF BUSINESS OR INDUSTRY  |   |                        |
| Catonsville   |         | Shangri La Nursing Home  |                  | Housewife   |                                     | Own Home   |   |                        |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |                  | 13c. CITY OR TOWN   |                                     | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER |
| Md.   |         |  |                  | Baltimore   |                                     |  |   | 402 Westgate Road      |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |                  |   |                                     |  |   |                        |
| First Middle Last   |         | First Middle Last  |                  |   |                                     |  |   |                        |
| Earle J. Carmine  |         | Eleanor Neal   |                  |   |                                     |  |   |                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |         | 16b. SOCIAL SECURITY NO.   |                  | 17. INFORMANT   |                                     | Address  |   |                        |
| No  |         | 216-28-8861  |                  | James B. Armiger, same as 13  |                                     |  |   |                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Probable Septicemia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Decubiti, German tract infection<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Bladder Cancer - Severe Peritonitis<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Days<br>Months<br>Years |         |  |                  |   |                                     |  |   |                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>604 X  |         |  |                  |   |                                     |  |   |                        |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |                        |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                     |  |   |                        |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                     |  |   |                        |
| 22a. I certify that (I) (this hospital) attended the deceased from 1960, 19, to 4/22, 1968, that (I) (we) lost saw the deceased alive on 4/18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |         | 22b. SIGNATURE<br>James J. Nolan   |                  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |                                     | 22c. DATE SIGNED<br>4/23/68  |   |                        |
| 22d. PHYSICIAN'S NAME (Type)  |         | 22e. ADDRESS   |                  |   |                                     |  |   |                        |
| James J. Nolan, M. D.   |         | 1 Mallowhill Ave., Baltimore, Md.  |                  |   |                                     |  |   |                        |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY  |                                     | 23d. LOCATION (City or Town) (County) (State)  |   |                        |
| Burial  |         | 68 25 April  |                  | Lorraine Park Cemetery  |                                     | Baltimore Md.  |   |                        |
| 24. FUNERAL DIRECTOR  |         | ADDRESS  |                  | 25a. REC'D BY REGISTRAR   |                                     | 25b. REGISTRAR'S SIGNATURE   |   |                        |
| Kirkley Funeral Home, Glen Burnie, Md.  |         |  |                  | DATE APR 24 1968  |                                     | Charles Judge  |   |                        |

05172

05172

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 410 (10)  
30M REV. 1-68

| 05170   |  |  |  |  |   |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |  |  | 05174  |  |  |  |  |                                   |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--|--|--|
| Item 1 Film G399 4/16/68 kk   |  |  |  |  |   |  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)<br>Edward   |  |  |  |  | First<br>CHANDLER   |  |  |  |  | Middle<br>F.  |  |  |  |  | Last<br>ARMSTRONG   |  |  |  |  | 2a. DATE OF DEATH<br>Month<br>4 / Day<br>10 / Year<br>68 |  |  |  |  | 2b. HOUR<br>9:40 AM               |  |  |  |  |
| 3. SEX<br>male  |  |  |  |  | 4. RACE<br>white  |  |  |  |  | 5. DATE OF BIRTH<br>3/15/83   |  |  |  |  | 6. AGE (In years<br>last birthday)<br>85 YRS.   |  |  |  |  | 7. UNDER 1 YEAR<br>MONTHS<br>DAYS                        |  |  |  |  | 8. UNDER 24 HRS.<br>HOURS<br>MIN. |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>MD.   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>Baltimore County Md.  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Mount Wilson   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Mt. Wilson State Hosp. |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Plant Foreman   |  |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>MD.   |  |  |  |  | 13b. COUNTY<br>Montgomery Silver Spring   |  |  |  |  | 13c. CITY OR TOWN<br>Silver Spring  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br>8505 Springvale                |  |  |  |  |                                   |  |  |  |  |
| 14. FATHER'S NAME<br>First<br>Edward  |  |  |  |  | Middle<br>Armstrong   |  |  |  |  | Last<br>Regina  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Regina   |  |  |  |  | Middle<br>Hall   |  |  |  |  | Last<br>Hall                      |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>NO   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>216-07-6531                          |  |  |  |  | 17. INFORMANT<br>Address<br>Records, Mt. Wilson State Hospital  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary fibrosis, interstitial</u><br>517 X<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. <u>5258</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Atherosclerotic Heart Disease, Pulm. Hbc</u>  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  | 20a. ADOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH <u>Yes</u>               |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                           |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/20/1968</u> , to <u>4/10/1968</u> , that (I) (we) lost<br>saw the deceased alive on <u>4/10/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |
| 22b. SIGNATURE<br><u>W Newcomer</u>   |  |  |  |  | DEGREE<br>M.D.  |  |  |  |  | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input checked="" type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>                    |  |  |  |  | 22c. DATE SIGNED<br><u>10 April '68</u>   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>William Newcomer, M.D.   |  |  |  |  | 22e. ADDRESS<br>Mount Wilson, Maryland  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><u>Burial</u>   |  |  |  |  | 23b. DATE<br><u>13 April 68</u>   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Woodlawn Cem.</u>  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Md.</u>                          |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>WIRKLEY Funeral Home, Glen</u>   |  |  |  |  | ADDRESS<br><u>Buenos Aires, Md.</u>   |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><u>APR 15 1968</u>   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |

4716

HEAD OF THE DEPT.

6816

1

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |                                 |  |                                   |                        |  |  |
|---|--|--|--|--|--|---|---------------------------------|--|-----------------------------------|------------------------|--|--|
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |                                 |  |                                   |                        |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |                                 |  | 2b. HOUR                          |                        |  |  |
| Gilbert Lane ATHEY  |  |  |  |  |  | Month 4 Day 22 Year 68  |                                 |  | 8:50 a.m.                         |                        |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |   | 6. AGE (In years last birthday) |  | IF UNDER 1 YEAR                   |                        | IF UNDER 24 HRS.                             |  |
| Male  |  | White  |  | 7/27/57  |  |   | 10 YRS.                         |  | MONTHS DAYS                       |                        | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH              |  |                                   |                        |  |  |
| Maryland  |  | U.S.A.   |  |  |  |   | Baltimore Md.                   |  |                                   |                        |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY |                        |  |  |
| Owings Mills  |  |  | Rosewood State Hosp.   |  |  | Dependent   |                                 |  | none                              |                        |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |                                 | 13d. INSIDE CITY LIMITS?   |                                   | 13e. STREET AND NUMBER |  |  |
| Md.   |  |  |  | Howard   |  | Simpsonville  |                                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   | 114 Hunting Lane       |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |   |                                 |  |                                   |                        |  |  |
| First Middle Last   |  |  | First Middle Last  |  |  |   |                                 |  |                                   |                        |  |  |
| Gilbert Roy Athey   |  |  | Margaret Jeanne O'Neill  |  |  |   |                                 |  |                                   |                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT Address   |                                 |  |                                   |                        |  |  |
| no  |  |  | none   |  |  | Rosewood Records, Owings Mills, Maryland  |                                 |  |                                   |                        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |                                 |  |                                   |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Orthostatic Necrotizing Pneumonia  |  |  |  |  |  |   |                                 |  |                                   |                        | 2 months                                     |  |
| 315x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Repeated Aspiration of Stomach Contents   |  |  |  |  |  |   |                                 |  |                                   |                        | 6 months                                     |  |
| (c)   |  |  |  |  |  |   |                                 |  |                                   |                        |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |                                 |  |                                   |                        |  |  |
| 3255 Encephalopathy with severe mental retardation  |  |  |  |  |  |   |                                 |  |                                   |                        |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY?   |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |                        |  |  |
|   |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |                                 | yes  |                                   |                        |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |                                 |  |                                   |                        |  |  |
|   |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |   |                                 |  |                                   |                        |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |                                 |  |                                   |                        |  |  |
|   |  |  |  |  |  |   |                                 |  |                                   |                        |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 11/21, 19 67, to 4/22, 19 68, that (X) (we) last saw the deceased alive on 4/22, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |                                 |  |                                   |                        |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |   |                                 |  |                                   |                        | 22c. DATE SIGNED                             |  |
| Richard A. Jones  |  |  |  |  |  |   |                                 |  |                                   |                        | 4/22/68                                      |  |
| 22d. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.   |  |  |  |  |  |   |                                 |  |                                   |                        | 22e. ADDRESS                                 |  |
|   |  |  |  |  |  |   |                                 |  |                                   |                        | Rosewood St. Hosp., Owings Mills, Md.        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |                                 |  |                                   |                        |  |  |
| Burial  |  | 4-25-68  |  | St Marys Cemetery  |  | Laurel Md.  |                                 |  |                                   |                        |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  | 25a. REC'D BY REGISTRAR   |                                 | 25b. REGISTRAR'S SIGNATURE   |                                   |                        |  |  |
| William Donaldson   |  |  |  |  |  | DATE  |                                 | APR 30 1968 Charles Judge  |                                   |                        |  |  |

08172

08172

08172

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05172

05176

|   |  |  |   |  |  |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) <b>AGNES R. BACHMAN</b>  |  |  | 2a. DATE OF DEATH <b>April</b> Month <b>22</b> , Day <b>1968</b> Year   |  |  | 2b. HOUR <b>9:15 A</b> M   |  |  |  |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>   |   | 5. DATE OF BIRTH <b>6/26/1883</b>  |  | 6. AGE (In years lost birthday) <b>84</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN       |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                      |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore</b> Md.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Catonsville</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph's Nursing Home</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Fallston</b>                                      |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>2601 Harford Rd.</b> |  |
| 14. FATHER'S NAME First Middle Last <b>Edward R. Roach</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Lynch</b>   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address <b>Mr. John S. Bachman-D-Same</b>                |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart Failure</b><br><b>782.4</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>782.4</b>  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>                  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1 June, 1968</b> , to <b>13 Apr, 1968</b> , that (I) (we) last saw the deceased alive on <b>23 Apr, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>William Goodman MD</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |   |  |  | 22c. DATE SIGNED <b>23 Apr 68</b>  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Dr. William Goodman</b>   |  |  |   |  |  | 22e. ADDRESS <b>1334 Sulphur Spring Rd.</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE <b>4/25/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>Long Green, Balto. Md.</b>                              |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc. Baltimore 21214</b>  |  |  |   | 25a. REC'D BY REGISTRAR <b>APR 25 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |  |  |  |

MEDICAL CERTIFICATION

100

1990

05177 Item 5 Division of Vital Records, 301 W. Preston Street, Baltimore, Maryland 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT

any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                  |  |   |  |   |  |   |  |
|--|------------------|--|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or Print) <b>Warren W. Baer</b>   |                  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>4</b> Day <b>13</b> Year <b>1968</b>       |  |   | 2b. HOUR <b>3:50 PM</b>  |   |  |
| 3. SEX <b>M</b>  | 4. RACE <b>W</b> | 5. DATE OF BIRTH <b>3/24/02</b>  | 6. AGE (In years last birthday) <b>65</b> YRS.  | IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b> | 2c. DATE PRONOUNCED DEAD Month <b>April</b> Day <b>13</b> Year <b>1968</b>                                 |   |  |
| 7a. BIRTHPLACE (State or foreign country) <b>PENNA.</b>  |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>Ba / Ho.</b>   |   |  |
| 10. CITY OR TOWN OF DEATH <b>RANDALLS TOWN</b>   |                  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>BALTIMORE COUNTY GEN. Hosp.</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>UNDERWRITER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE</b> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>PENNA.</b>  |                  |  | 13b. COUNTY <b>Phila.</b>   |  | 13c. CITY OR TOWN <b>Phila.</b>               | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO               | 13e. STREET AND NUMBER <b>7244 RUPERT ST.</b> |  |
| 14. FATHER'S NAME First <b>FREDERICK E.</b> Middle <b>BACR</b> Last <b>BACR</b>  |                  |  | 15. MOTHER'S MAIDEN NAME First <b>Elizabeth</b> Middle <b>SCHAEFFER</b> Last <b>SCHAEFFER</b>                   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>  |                  |  | 16b. SOCIAL SECURITY NO. <b>4129</b>  |  |   | 17. INFORMANT <b>Harold Baer</b> ADDRESS <b>3673 CLIFMAR RD. RANDALLS TOWN MD.</b>                         |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-vascular disease</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>       |                  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4221</b>   |                  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY Month, Day, Year <b>19</b>                               |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>James N. Frederick</b> M.D.  |                  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   | 22b. DATE SIGNED <b>4/13/68</b>  |   |  |
| EXAMINER'S NAME (Type) <b>James N. Frederick</b>   |                  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   | ADDRESS (Street, city, town, or county) <b>Ba / Ho.</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |                  | 23b. DATE <b>4/17/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>MT. PEACE</b>  |   | 23d. LOCATION (City or Town) (County) (State) <b>PHILA. PA.</b>  |   |  |
| 24. FUNERAL DIRECTOR <b>MANNAL Funeral Home</b> ADDRESS <b>Phila. PA.</b>  |                  |  |   | 25a. REC'D BY REGISTRAR <b>E. B. MacNabb</b> DATE <b>APR 16 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |   |  |

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Handwritten signature

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |                   |   |  |  |                                   |  |                             |  |
|---|--|--|--|--|-------------------|---|--|--|-----------------------------------|--|-----------------------------|--|
| 05174   |  |  |  |  |                   | 05178   |  |  |                                   |  |                             |  |
| 1. DECEASED-NAME (Type or print) First Middle Last  |  |  |  |  |                   | 2a. DATE OF DEATH Month Day Year  |  |  | 2b. HOUR                          |  |                             |  |
| THOMAS ARCHER BAILEY  |  |  |  |  |                   | 4 / 28 / 68   |  |  | 12:50 AM                          |  |                             |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |                   |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS       |  | IF UNDER 24 HRS. HOURS MIN. |  |
| Male  |  | Cauc   |  | 1/16/1895  |                   |   | 73 YRS.  |  |                                   |  |                             |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. COUNTY OF DEATH  |  |  |                                   |  |                             |  |
| Balto.  |  | USA  |  |  |                   | BALTO Md.   |  |  |                                   |  |                             |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                             |  |
| Towson, Md. 21204   |  |  | Baltimore Med Center   |  |                   | XXXXXXX, Retired  |  |  | -----                             |  |                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER            |  |                             |  |
| Md.   |  |  | Baltimore  |  | Baltimore         |   | YES  |  | 4413 Marble Hall Rd.              |  |                             |  |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |                   |   |  |  |                                   |  |                             |  |
| Thomas Bailey   |  |  | Mary   |  |                   |   |  |  |                                   |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |  |                   | 17. INFORMANT   |  |  | Address                           |  |                             |  |
| XXXXXXX WW I  |  |  | 215037531  |  |                   | PATIENTS CHART  |  |  |                                   |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |                   |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                             |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |                   |   |  |  |                                   |  |                             |  |
| IMMEDIATE CAUSE (a) <u>Respiratory failure</u>  |  |  |  |  |                   |   |  |  |                                   |  |                             |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration</u>  |  |  |  |  |                   |   |  |  |                                   |  |                             |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intracranial bleeding</u>   |  |  |  |  |                   |   |  |  |                                   |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |                   |   |  |  |                                   |  |                             |  |
| 331X  |  |  |  |  |                   |   |  |  |                                   |  |                             |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                    |  |  |                                   |  |                             |  |
|   |  |  |  |  |                   |   |  |  |                                   |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                   |   |  |  |                                   |  |                             |  |
|   |  |  |  |  |                   |   |  |  |                                   |  |                             |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                   |   |  |  |                                   |  |                             |  |
|   |  |  |  |  |                   |   |  |  |                                   |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-27, 1968</u> , to <u>4-28, 1968</u> , that (I) (we) last saw the deceased alive on <u>4-28, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                   |   |  |  |                                   |  |                             |  |
| 22b. SIGNATURE <u>J. M. deCastro</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |  |  |  |                   |   |  |  |                                   | 22c. DATE SIGNED <u>4-28-68</u>              |                             |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Dr. J. M. deCastro</u>  |  |  |  |  |                   |   |  |  |                                   | 22e. ADDRESS <u>GBMC</u>                     |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                   | 23d. LOCATION (City or Town) (County) (State)   |  |  |                                   |  |                             |  |
| Burial  |  | 5-1-1968   |  | Balto. Cem.  |                   | Balto. City, Md.  |  |  |                                   |  |                             |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  | 25a. REC'D BY REGISTRAR  |                   | 25b. REGISTRAR'S SIGNATURE  |  |  |                                   |  |                             |  |
| Wm. Cook-Brooks, Inc. 1217 St. Paul St. 21202   |  |  |  | DATE <u>APR 29 1968</u>  |                   | <u>Charles Judge</u>  |  |  |                                   |  |                             |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M) 1 and 2

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |   |   |  |  |  |  |
|---|--|---|--|---|---|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |   |   |  |  |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |  |  |  |
| 1. DECEASED-NAME (Type or print) <u>Gerry</u> <u>McDonald</u> <u>Baldwin</u>  |  |   |  |   | 2a. DATE OF DEATH <u>April</u> <u>13</u> <u>Day</u> <u>68</u> <u>Year</u>         |   |  | 2b. HOUR <u>11:10 P.M.</u>   |  |  |
| 3. SEX <u>Male</u>  |  | 4. RACE <u>White</u>  |  | 5. DATE OF BIRTH <u>May 10, 1899</u>  |   | 6. AGE (In years last birthday) <u>68</u> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <u>  </u> DAYS <u>  </u><br>IF UNDER 24 HRS.<br>HOURS <u>  </u> MIN. <u>  </u> |  |  |
| 7a. BIRTHPLACE (State or foreign country) <u>Penn.</u>  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <u>Balto.</u> Md.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <u>White Hall</u>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>  </u> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Egg Salesman</u> |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Egg Bus.</u>  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>  |  |   | 13b. COUNTY <u>Balto.</u>  |   | 13c. CITY OR TOWN <u>White Hall</u>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <u>  </u>                       |  |
| 14. FATHER'S NAME First <u>Dr. Thomas</u> Middle <u>C.</u> Last <u>Baldwin</u>  |  |   |  | 15. MOTHER'S MAIDEN NAME First <u>Rozella</u> Middle <u>McDonald</u> Last <u>  </u>   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown) <u>No</u> (If yes give war or dates of service) <u>  </u>   |  |   |  | 16b. SOCIAL SECURITY NO. <u>216-38-3805</u>   |   | 17. INFORMANT <u>Marjorie C. Baldwin</u> Address <u>White Hall, Md.</u>                                     |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary Infarction</u><br><u>410.9</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>  </u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>  </u> |  |   |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>  </u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>4201</u>   |  |   |  |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION <u>  </u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>  </u>  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>  </u>               |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19</u> P.M. <u>  </u> |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>  </u>   |   |   |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <u>  </u>              |  | 21f. LOCATION Street or R.F.D. No. <u>  </u> City or Town <u>  </u> County <u>  </u> State <u>  </u>  |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/1</u> , 19 <u>68</u> , to <u>4/13</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/13</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |  |   |  |   |   |   |  |  |  |  |
| 22b. SIGNATURE <u>Herbert Mueller MD</u> DEGREE <u>  </u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |   |  |   |   | 22c. DATE SIGNED <u>4-16-68</u>   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>e-HERBERT MOELLER</u>   |  |   |  |   |   | 22e. ADDRESS <u>PARKTOWN - MD - 21120</u>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE <u>4/17/68</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Centre Presbyterian Cem</u>   |   | 23d. LOCATION (City or Town) <u>New Park</u> (County) <u>Penn.</u> (State) <u>  </u>                        |  |  |  |  |
| 24. FUNERAL DIRECTOR <u>J. Jacob Hartenstein</u> ADDRESS <u>New Freedom, Pa.</u>  |  |   |  | 25a. REC'D BY REGISTRAR <u>  </u> DATE <u>APR 22 1968</u>   |   | 25b. REGISTRAR'S SIGNATURE <u>Johnas Juge</u>   |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-17-68  
30M REV. 11-68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |   |   |  |  |  |
|--|--|---|--|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |   |   |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |   |   |  |  |  |
| 05176  |  |   |  |   |   |   |  |  |  |
| 05180  |  |   |  |   |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First Middle Last  |   |   | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
| Howard   |  |   | Clifton Barker   |   |   | Month Day Year<br>4 17 68   |  | 4 a M  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  |
| Male   |  | White   |  | July 27, 1890   |   | 77 YRS.   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  | Md.  |  |
| Maryland   |  | U. S. A.  |  |   |   | Baltimore   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Randallstown   |  |   | Chapel Hill Nursing Home   |   |   | Conductor   |  | Transit  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |   | 13b. COUNTY  |   |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| md.  |  |   | Carroll  |   |   | Sykesville  |  | Route 2  |  |
| 14. FATHER'S NAME  |  |   | 15. MOTHER'S MAIDEN NAME   |   |   |   |  |  |  |
| First Middle Last  |  |   | First Middle Last  |   |   |   |  |  |  |
| Jeremiah Barker  |  |   | Unknown  |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |   | 16b. SOCIAL SECURITY NO.   |   |   | 17. INFORMANT   |  | Address  |  |
| No   |  |   | 213-10-1136  |   |   | Mrs. Beatrice Scott   |  | Sykesville, Md.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |   |   |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |   |   |   |  |  |  |
| IMMEDIATE CAUSE (a) Multiple Myeloma   |  |   |  |   |   |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |   |   |  |  |  |
| (b)  |  |   |  |   |   |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |   |   |  |  |  |
| (c)  |  |   |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |   |  |   |   |   |  |  |  |
| 203X   |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
|  |  |   |  |   |   |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |
|  |  | HOUR A.M. Month Day Year<br>P.M. 19   |  |   |   |   |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) |  | 21f. LOCATION   |   | City or Town  |  | County State   |  |
| White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |   |  |   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 29, 1965, to April 16, 1968, that (I) (we) lost saw the deceased alive on April 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE   |  |   |  |   |   | 22c. DATE SIGNED  |  |  |  |
| Naci N. Buyukunsal, M.D.   |  |   |  |   |   | 4-17-68   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |   |  |   |   | 22e. ADDRESS  |  |  |  |
| Naci N. Buyukunsal, M.D.   |  |   |  |   |   | Obrecht Road, Sykesville, Md.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |  | Md.  |  |
| Burial   |  | 4-20-68   |  | Good Shepherd Cemetery  |   | Sykesville  |  | Ellicott City  |  |
| 24. FUNERAL DIRECTOR   |  |   |  |   |   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |
| Harry W. Haight  |  |   |  |   |   | DATE APR 19 1968  |  | Charles Judge  |  |

05130

05130

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| 1. DECEASED-NAME (Type or print)   |  |                              |  | First  | Middle | Last  | 2a. DATE OF DEATH               |  |  | 2b. HOUR               |                  |
|--|--|------------------------------|--|--|--------|---|---------------------------------|--|--|------------------------|------------------|
| Cecilia  |  |                              |  |  |        | Basil   | April                           | 30   | 1968   | M                      |                  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH   |        |   | 6. AGE (In years lost birthday) |  | IF UNDER 1 YEAR  |                        | IF UNDER 24 HRS. |
| Female   |  | White                        |  | February 17, 1885  |        |   | 83 YRS.                         |  | MONTHS   | DAYS                   | HOURS MIN.       |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. COUNTY OF DEATH  |                                 |  |  |                        |                  |
| Md.  |  | U.S.                         |  |  |        | Baltimore   |                                 | Md.  |  |                        |                  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                        |                  |
| Cockeysville   |  |                              | Md. Masonic Home   |  |        | Housewife   |                                 |  |  |                        |                  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              | 13b. COUNTY  |  |        | 13c. CITY OR TOWN   |                                 | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER |                  |
| Md.  |  |                              | H. H.  |  |        | Annapolis   |                                 | YES  |  | 22 Madison Rd.         |                  |
| 14. FATHER'S NAME  |  |                              | 15. MOTHER'S MAIDEN NAME   |  |        |   |                                 |  |  |                        |                  |
| First Middle Last  |  |                              | First Middle Last  |  |        |   |                                 |  |  |                        |                  |
| Jesse Wilson   |  |                              | Jane Clara Ritz  |  |        |   |                                 |  |  |                        |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |                              | 16b. SOCIAL SECURITY NO.   |  |        | 17. INFORMANT   |                                 |  |  |                        |                  |
|  |  |                              | 215-56-5423-21   |  |        | Records of Md. Masonic Home Cockeysville  |                                 |  |  |                        |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                              |  |  |        |   |                                 |  |  |                        |                  |
| PART 1. DEATH WAS CAUSED BY:   |  |                              |  |  |        |   |                                 |  |  |                        |                  |
| IMMEDIATE CAUSE (a) Cerebral arteriosclerosis hemorrhage   |  |                              |  |  |        |   |                                 |  |  |                        |                  |
| 2509 DUE TO, OR AS A CONSEQUENCE OF  |  |                              |  |  |        |   |                                 |  |  |                        |                  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Direct Melitus  |  |                              |  |  |        |   |                                 |  |  |                        |                  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |                              |  |  |        |   |                                 |  |  |                        |                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                              |  |  |        |   |                                 |  |  |                        |                  |
| 260X   |  |                              |  |  |        |   |                                 |  |  |                        |                  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |        | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |                                 |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                        |                  |
|  |  |                              |  |  |        |   |                                 |  |  |                        |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |                                 |  |  |                        |                  |
|  |  |                              |  |  |        |   |                                 |  |  |                        |                  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |        | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |                                 |  |  |                        |                  |
|  |  |                              |  |  |        |   |                                 |  |  |                        |                  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1965, to April 30, 1968, that (I) (we) last saw the deceased alive on April 28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 6 A.M. 4/30/68 |  |                              |  |  |        |   |                                 |  |  |                        |                  |
| 22b. SIGNATURE   |  |                              |  |  |        | DEGREE  |                                 |  | 22c. DATE SIGNED   |                        |                  |
| James H. Hamed   |  |                              |  |  |        |   |                                 |  | 4/30/68  |                        |                  |
| 22d. PHYSICIAN'S NAME (Type)   |  |                              |  |  |        | 22e. ADDRESS  |                                 |  |  |                        |                  |
| James H. Hamed   |  |                              |  |  |        | Masonic Home  |                                 |  |  |                        |                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                              | 23b. DATE  |  |        | 23c. NAME OF CEMETERY OR CREMATORY  |                                 |  | 23d. LOCATION (City or Town) (County) (State)                        |                        |                  |
| Burial   |  |                              | 5/2/68   |  |        | Cedar Bluff   |                                 |  | Annapolis, Md.   |                        |                  |
| 24. FUNERAL DIRECTOR   |  |                              |  |  |        | 25a. REC'D BY REGISTRAR   |                                 |  | 25b. REGISTRAR'S SIGNATURE   |                        |                  |
| 6212 Balt. Nat. Pike Wm. Cook-Brooks West Inc Balt. Md. 21228  |  |                              |  |  |        | DATE MAY 6 1968   |                                 |  | Charles Judge  |                        |                  |

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DATE: 1961-11-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15-14  
30M REV. 1/68

| 05178  |  |  |  |  |   |  |  |  |  | 05182   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  | First Middle Last   |  |  |  |  | 2a. DATE OF DEATH   |  |  |  |  | 2b. HOUR  |  |  |  |  |   |  |  |  |  |
| Ellis  |  |  |  |  | L. Beavin   |  |  |  |  | April Month 4, Day 1968   |  |  |  |  | 11:45   |  |  |  |  |   |  |  |  |  |
| 3. SEX   |  |  |  |  | 4. RACE   |  |  |  |  | 5. DATE OF BIRTH  |  |  |  |  | 6. AGE (In years<br>last birthday)  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |  |  |  |
| Male   |  |  |  |  | White   |  |  |  |  | 1/29/02   |  |  |  |  | 86 YRS.   |  |  |  |  |   |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH  |  |  |  |  | Md.                                       |  |  |  |  |
| Maryland   |  |  |  |  | U.S.  |  |  |  |  |   |  |  |  |  | Baltimore   |  |  |  |  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired)   |  |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |  |   |  |  |  |  |
| Catonsville  |  |  |  |  | Spring Grove State Hospital   |  |  |  |  | letterer & grainer  |  |  |  |  | US Gov't.   |  |  |  |  |   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE   |  |  |  |  | 13b. COUNTY   |  |  |  |  | 13c. CITY OR TOWN   |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER                    |  |  |  |  |
| Maryland   |  |  |  |  | Anne Arundel  |  |  |  |  | Annapolis   |  |  |  |  | YES   |  |  |  |  | 16 Woodlawn Avenue                        |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  | First Middle Last   |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  | First Middle Last   |  |  |  |  |   |  |  |  |  |
| Elmo   |  |  |  |  | Beavin  |  |  |  |  | Lula  |  |  |  |  | Scott   |  |  |  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  |  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |  |  | 17. INFORMANT   |  |  |  |  | Address   |  |  |  |  |   |  |  |  |  |
|  |  |  |  |  | 213-30-0689   |  |  |  |  | Records: Spring Grove State Hospital  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4109 Myocardial Infarction, acute, death<br>DUE TO, OR AS A CONSEQUENCE OF with prev. diaphragmatic M.I.<br>(b) Arteriosclerotic Cardiovascular Ht. Dis. 10 yrs.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Arteriosclerosis, Senile 10 yrs.<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. 4301 |  |  |  |  |   |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |  |  |   |  |  |  |  |
|  |  |  |  |  |   |  |  |  |  |   |  |  |  |  | 2 hrs.  |  |  |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |   |  |  |  |  |   |  |  |  |  | Pneumonia, recent, treated, improved.   |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |  |   |  |  |  |  |
|  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
|  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 4/27/1961, to 4/4/1968, that (I) (we) last<br>saw the deceased alive on 4/4/1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  | DEGREE  |  |  |  |  | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>                               |  |  |  |  | 22c. DATE SIGNED  |  |  |  |  |   |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  |  |  |  | Anthony J. Young, M.D.  |  |  |  |  | 22e. ADDRESS  |  |  |  |  | Spring Grove State Hospital   |  |  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  |  |  |  | 23b. DATE   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |  |   |  |  |  |  |
| Burial   |  |  |  |  | Apr. 6, 1968  |  |  |  |  | Cedar Bluff Cemetery  |  |  |  |  | Annapolis A.A. Md.  |  |  |  |  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  | ADDRESS   |  |  |  |  | 25a. REC'D BY REGISTRAR   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |   |  |  |  |  |
| HOPPING FUNERAL HOME - Annapolis, Md.  |  |  |  |  |   |  |  |  |  | DATE APR 8 - 1968   |  |  |  |  | Charles Judge   |  |  |  |  |   |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| 05178  |  | 05183   |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Katharina</i> First <i>Becker</i> Middle Last   |  | 2a. DATE OF DEATH<br>Month <i>4</i> Day <i>3</i> Year <i>68</i> 2b. HOUR<br><i>9:30</i> A M   |  |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>White</i>  | 5. DATE OF BIRTH<br><i>5-29-83</i>  | 6. AGE (In years<br>lost birthday)<br><i>84</i> YRS. <del>83</del> <del>82</del> |
| 7a. BIRTHPLACE (State or foreign<br>country) <i>Germany</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><i>Garrison</i> Baltimore Md.                              |
| 10. CITY OR TOWN OF DEATH<br><i>Garrison</i>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <i>Foxleigh Conv. Center</i> | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) <i>Own Home</i>  | 12b. KIND OF BUSINESS OR<br>INDUSTRY <i>N one</i>                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <i>md</i>   | 13b. COUNTY <i>Balto.</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET AND NUMBER<br><i>716 Aisquith St.</i>                                |
| 14. FATHER'S NAME First <i>George</i> Middle Last <i>Becker</i>  | 15. MOTHER'S MAIDEN NAME First <i>Emma</i> Middle Last <i>Boss</i>   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <i>NO</i> (If yes give war or dates of service) <i>NO</i>                              |  |
| 16b. SOCIAL SECURITY NO.<br><i>213-48-1509</i>   |  | 17. INFORMANT Address <i>5524 Robinwood Rd.</i><br><i>Mr. Frederick Becker</i>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i><br><i>4369</i> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>cardiac</i> |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>Hours</i>                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>331X</i>  |  |   |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?          |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                              | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3-4</i> , 19 <i>68</i> , to <i>4-3</i> , 19 <i>68</i> , that (I) (we) lost<br>saw the deceased alive on <i>4-2</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above. (I) (we) (did) (did not) view the body after death.                              |  |   |  |
| 22b. SIGNATURE<br><i>David I. Miller</i> DEGREE ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>  |  | 22c. DATE SIGNED<br><i>4/3/68</i>   |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <i>David I. Miller</i>   |  | 22e. ADDRESS<br><i>9115 Reisterstown Rd.</i>  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><i>Burial</i>  | 23b. DATE<br><i>4/5/68</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Loudon Park</i>  | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore MD</i>             |
| 24. FUNERAL DIRECTOR<br><i>J. I. Stansbury</i> ADDRESS<br><i>6411 Windsor Mill Rd.</i>   |  | 25a. REC'D BY REGISTRAR<br>DATE <i>APR 5 1968</i>   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                               |

MEDICAL CERTIFICATION

X

02188

02178

UNITED STATES OF AMERICA  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

| NO. | DATE | PLACE | PLANT | COLLECTOR | LOCALITY | REMARKS |
|-----|------|-------|-------|-----------|----------|---------|
| 1   |      |       |       |           |          |         |
| 2   |      |       |       |           |          |         |
| 3   |      |       |       |           |          |         |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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|  |  |   |  |  |
|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Rudolph August Bender   |  | 2a. DATE OF DEATH<br>4-30-68 Month Day Year                                     |  | 2b. HOUR<br>M                              |
| 3. SEX<br>M  | 4. RACE<br>Cauc.   | 5. DATE OF BIRTH<br>Sept. 13, 1882  |  | 6. AGE (In years last birthday)<br>85 YRS. |
| 7a. BIRTHPLACE (State or foreign country)<br>Germany   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. COUNTY OF DEATH<br>Baltimore  |  | Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>8204 Carrbridge Circle |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  | 12b. KIND OF BUSINESS OR INDUSTRY          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Towson   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET AND NUMBER<br>(11)             |
| 14. FATHER'S NAME First Middle Last<br>August Bender   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Elizabeth ?                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br>284-03-6554A  | 17. INFORMANT Address<br>Elizabeth A. Bleckaz, 8204 Carrbridge Circle Towson, 21204  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY HEART DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 MINUTES<br>YEARS |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4201   |  |   |  |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/15, 1967, to 4/30, 1968, that (I) (we) last saw the deceased alive on 3/26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |
| 22b. SIGNATURE<br>Donald L. Somerville MD  |  | 22c. DATE SIGNED<br>5/1/68  | 22d. PHYSICIAN'S NAME (Type)<br>DONALD L. SOMERVILLE, MD.  |  |
| 22e. ADDRESS<br>25 W. PA. AVE TOWSON, MD 21204   |  |   |  |  |
| 23a. BURIAL, CREMATION, ETC. (Specify)<br>Burial   | 23b. DATE<br>5-3-1968  | 23c. NAME OF CEMETERY OR CREMATORY<br>Prospect Hill Cemetery                    | 23d. LOCATION (City or Town) (County) (State)<br>Towson, Md. 21204   |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson, Towson, Md. 21204  |  | 25a. REC'D BY REGISTRAR<br>DATE MAY 6 1968                                      | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  |   |  |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)  |  | First  |  | Middle  |  | Last   |  | 2a. DATE OF DEATH<br>Month Day Year                                      |  | 2b. HOUR<br>24 HRS.   |  |
| Edward   |  | F  |  | Bennett   |  | April  |  | 28 1968  |  | 7:40 AM   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| Male   |  | White  |  | 3/7/98  |  | 70 YRS.  |  |  |  |   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |   |  |
| Lake City, Florida   |  | U.S.A.   |  |   |  | Baltimore Md.  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |   |  |
| Randallstown   |  | Balto. County Gen Hosp   |  | Cab Driver  |  | Taxicabs   |  |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |   |  |
| Md   |  | —  |  | Balto   |  | YES  |  | 5202 Wilton Hgts Ave   |  |   |  |
| 14. FATHER'S NAME  |  | First  |  | Middle  |  | Last   |  | 15. MOTHER'S MAIDEN NAME   |  | First Middle Last   |  |
| Frank  |  | Bennett  |  |   |  |  |  | Mrs. Mary J. Bennett   |  | Balto. Md   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | Address  |  |  |  |   |  |
| No   |  | 216-07-1374  |  | Chart   |  | 5202 Wilton Hgts Ave   |  | 21215  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4120 Bronchopneumonia<br>DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF (c) H A C V D<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>DAYS<br>Months<br>YRS |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>443X  |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |  | County   |  | State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  |   |  |  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  |   |  |  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)   |  | (County)   |  | (State)   |  |
| Burial   |  | 5/1/68   |  | Lake View Memorial Park   |  |  |  |  |  | Md.   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |   |  |
| Horing Bryan   |  | DATE MAY 01 1968   |  | Winkler Judge   |  |  |  |  |  |   |  |

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RECEIVED  
CREDITED  
HARD

CHUCK COOK MD BALTIMORE

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |  |   |   |  |
|---|--|--|--|---|--|---|--|--|---|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |   |   |  |
| 1. DECEASED-NAME<br>(Type or Print)   |  |  | First<br><i>Henry J. Beran</i>   |   |  | Middle  |  |  | Last  |   |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>White</i>                    |  | 5. DATE OF BIRTH<br><i>June 8, 1912</i>   |  | 6. AGE (In years last birthday)<br><i>55</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS    DAYS    HOURS    MIN. |   | 2a. DATE KNOWN OF ESTI-DEATH<br><input checked="" type="checkbox"/> Month <i>April</i> Day <i>18</i> Year <i>1968</i> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Baltimore</i>  |  |  | 2c. DATE PRONOUNCED DEAD<br>Month <i>April</i> Day <i>18</i> Year <i>1968</i>                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Essex</i>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>954 Thompson Blvd</i> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Welder</i>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Beth. Steel</i>   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>   |  |  | 13b. COUNTY <i>Baltimore</i>   |   |  | 13c. CITY OR TOWN<br><i>Essex</i>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>First <i>Joseph</i> Middle <i>Beran</i>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Julia</i> Middle <i>-</i>   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <i>No</i>   |  |  | 16b. SOCIAL SECURITY NO.<br><i>218 01 3826</i>  |   |  |
| 17. INFORMANT<br><i>Louise Beran</i>  |  |  | ADDRESS<br><i>2531 E. Ashland Avenue</i>   |   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>A-S-C-V- Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>4129</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>4221</i>  |  |  |  |   |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION<br><i>4-19-68</i>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><i>None</i>   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.    P.M. <i>19</i>                                      |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                             |   |  | 21f. LOCATION Street or R.F.D. No.    City or Town    County    State   |  |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |   |  |   |  |  |   |   |  |
| ACTUAL SIGNATURE<br><i>Melvin B. Davis</i>  |  |  | EXAMINER'S NAME (Type)<br><i>MELVIN B. DAVIS, M.D.</i>   |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  | 22b. DATE SIGNED<br><i>4-19-68</i>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Cremation</i>   |  |  | 23b. DATE<br><i>April 20, 1968</i>   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Green Mount Crematory</i>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Maryland</i>                     |   |  |
| 24. FUNERAL DIRECTOR<br><i>Theresa</i>  |  |  | ADDRESS<br><i>1211 Chesaco Avenue</i>  |   |  | 25a. REC'D BY REGISTRAR<br><i>APR 22 1968</i>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>K. Charles Jones</i>   |   |  |

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05180

David J. Brown

State Farm, 415

750 Thompson Blvd

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois

Chicago, Illinois



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |   |   |  |   |              |
|---|--|---|--|---|---|---|--|---|--------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |   |   |  |   |              |
| CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |   |              |
| 05183   |  |   |  |   |   |   |  |   |              |
| 05187   |  |   |  |   |   |   |  |   |              |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Laura E. Bethke   |  |   |  |   | 2a. DATE OF DEATH<br>April Month 9 Day 68 Year                                  |   |  | 2b. HOUR<br>M   |              |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>July 25, 1887   |   | 6. AGE (In years last birthday)<br>80 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |              |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |              |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Summit Nursing Home |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>None   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>None   |  |   |              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>STATE Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>402 N. Athol Ave.             |              |
| 14. FATHER'S NAME First Middle Last<br>Louis Rever  |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Ella Francis Gibson   |   |   |  |   |              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, on, or unknown) No   |  | 16b. SOCIAL SECURITY NO.<br>212.07.9910   |  | 17. INFORMANT Address<br>Nursing Home Records, Catonsville Md   |   |   |  |   |              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>A.S.C.V.D.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>lost.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 min   |              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br>4201  |  |   |  |   |   |   |  |   |              |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |              |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |   |              |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |  |   | 21f. LOCATION Street or R.F.D. No.  |   | City or Town   |   | County State |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec, 1968, to 4/9, 1968, that (I) (we) last saw the deceased alive on 4/9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |  |   |              |
| 22b. SIGNATURE<br>J. C. Poyard MD   |  |   |  |   |   |   |  | 22c. DATE SIGNED  |              |
| 22d. PHYSICIAN'S NAME (Type)<br>J. C. Poyard  |  |   |  | 22e. ADDRESS<br>3325 Federal Ave  |   |   |  |   |              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>4/12/68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park   |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Baltimore, Md                       |  | 25a. RECEIVED BY REGISTRAR<br>APR 15 1968               |              |
| 24. FUNERAL DIRECTOR<br>J.T. Stansbury 6411 Windsor Mill Rd,  |  |   |  | ADDRESS   |   | 25b. REGISTRAR'S SIGNATURE  |  |   |              |

78130

UNITED STATES DEPARTMENT OF AGRICULTURE

08130

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

REPORT OF THE SECRETARY OF AGRICULTURE

ON THE PROGRESS OF AGRICULTURE

IN THE UNITED STATES

FOR THE YEAR 1913

AND THE PROGRESS OF AGRICULTURE

IN THE DISTRICT OF COLUMBIA

FOR THE YEAR 1913

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

| 05184  |  |  |  |  |  |  |  |   |  |  |  | 05188   |  |  |  |   |  |  |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |   |  |  |  | CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>LEE</b>   |  |  |  | First <b>A.</b>  |  |  |  | Middle <b>BINDSEIL</b>  |  |  |  | Last <b>SR.</b>   |  |  |  | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>20</b> Year <b>1968</b>                      |  |  |  | 2b. HOUR-<br>10 <sup>42</sup> <sub>AM</sub> |  |  |  |
| 3. SEX<br><b>Male</b>  |  |  |  | 4. RACE<br><b>White</b>  |  |  |  | 5. DATE OF BIRTH<br><b>Jan 1, 1886</b>  |  |  |  | 6. AGE (in years<br>last birthday)<br><b>82</b> YRS.  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN.              |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Maryland</b>   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  | Md.   |  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Summit Nursing Home</b>                                      |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Electrician</b>  |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |   |  |  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE <b>Maryland</b>   |  |  |  | 13b. COUNTY <b>Baltimore</b>   |  |  |  | 13c. CITY OR TOWN<br><b>Arbutus</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  | 13e. STREET AND NUMBER<br><b>1313 Stevens Avenue 21227</b>                              |  |  |  |   |  |  |  |
| 14. FATHER'S NAME<br>First <b>Anton</b> Middle <b>Bindseil</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Bessie</b> Middle <b>Thomas</b>   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |  | 17. INFORMANT<br>Address <b>21227</b><br><b>Mr. Lee A. Bindseil, Jr. 820 Seckel Cr.</b> |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>pneumonia</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD</b><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. |  |  |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 wks</b><br><b>2 wks</b><br><b>?</b>     |  |  |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>4-23-68</b>   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |   |  |  |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory,<br>office building, etc.)  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-20-68</b> to <b>4-20-68</b> , that (I) (we) last<br>saw the deceased alive on <b>4-20-68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Earl Pass M.D.</b>  |  |  |  | DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>4-20-68</b>  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>I. EARL PASS</b>   |  |  |  | 22e. ADDRESS<br><b>4001 WILKENS AVE</b>  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>  |  |  |  | 23b. DATE<br><b>4-23-1968</b>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                     |  |  |  |   |  |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>  |  |  |  | ADDRESS  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 22 1968</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |   |  |  |  |   |  |  |  |

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CERTIFICATE OF DEATH

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|   |  |  |  |   |  |   |  |  |  |  |  |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Timothy</b>  |  | First  |  | Middle  |  | Last  |  | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>8</b> Year <b>1968</b>    |  | 2b. HOUR<br><b>1:25</b>                          |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>6-24-1947</b>  |  | 6. AGE (In years last birthday)<br><b>20</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                     |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore</b><br><b>Towson</b> Md.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Student</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>ST. Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>914 Fairway Drive</b>                   |  |  |  |
| 14. FATHER'S NAME<br><b>Warren</b>  |  | First  |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME<br><b>Emilie</b>                            |  | First<br>Middle<br>Last<br><b>Burgemeister</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b>  |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Address<br><b>Warren Bittrick 914 Fairway Drive</b>                            |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive Gastro Intestinal Hemorrhage</b><br>536.9 DUE TO, OR AS A CONSEQUENCE OF<br>Uremic Colitis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Lupus Nephritis</b><br>(c) <b>Lupus Nephritis</b> |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>578x  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County   |  | State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-21-</b> <b>1968</b> , to <b>4-8</b> <b>1968</b> , that (I) (we) last saw the deceased alive on <b>4-8</b> <b>1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Dr. Lawrence Misanik M.D.</b>  |  | DEGREE   |  | ATTENDING PHYS. <input type="checkbox"/>  |  | MED. DIRECTOR <input type="checkbox"/>  |  | STAFF PHYS. <input checked="" type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>4-8-1968</b>              |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Apr. 10, 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Memorial</b>  |  | 23d. LOCATION (City or Town)<br><b>Timonium, Md.</b>  |  | (County)   |  | (State)  |  |
| 24. FUNERAL DIRECTOR<br><b>Ulrich Funeral Home 4210 Belair Road.</b>  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 11 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MD-ATS-14  
30M REV. 1/68

MEDICAL CERTIFICATION

|  |  |  |   |   |   |   |  |
|--|--|--|---|---|---|---|--|
| 05186  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |   |   |   | 05190   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First  | Middle  | Last  | 2a. DATE OF DEATH<br>Month Day Year   |   | 2b. HOUR<br>A.M.<br>P.M.                 |
| William  |  | H.   | Blessing  |   | April 2 1968  |   | 10:30                                    |
| 3. SEX   | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |
| male   | white  |  | April 1, 1886   |   | 82 YRS.   |   |  |
| 7a. BIRTHPLACE (State or foreign country)  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   |  |
| Maryland   | U.S.A.   |  |   |   | Baltimore Md.   |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| Towson   | Dulaney Towson Nursing Home  |  | salesman  |   | Newport Goods   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER                   |
| Maryland   |  |  | 21207   |   |   |   | 3104 Ferndale Ave 21207 Md.              |
| 14. FATHER'S NAME<br>First Middle Last   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)   |   | 16b. SOCIAL SECURITY NO.  |  |
| George Blessing  |  | Katherine  |   | X   |   | 212-01-5367   |  |
| 17. INFORMANT  |  | Address  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4201<br>Senility |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1963, to April 2, 1968 that (I) (we) last saw the deceased alive on Apr 2nd 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |   |   |   |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |   | 22d. PHYSICIAN'S NAME (Type)  |   | 22e. ADDRESS  |  |
| M. Paul Byers  |  | 4/2/68   |   | M. Paul Byers   |   | 5420 York Rd Baltimore Md   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)                                   |  |
| Burial   |  | 4-5-1968   |   | Wood Ridge  |   | Baltimore City Md   |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |   | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |  |
| James Byers  |  | 8728 Liberty Rd  |   | DATE APR 5 1968   |   | William Judge   |  |

05180

THE STATE OF TEXAS

05180

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 10174  
30M REV. 7/68

05187

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05191

|  |  |  |   |   |  |   |  |
|--|--|--|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>ETHEL LUCRETIA BOUNDS</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>3</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>11:30</b> M  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>  |   | 5. DATE OF BIRTH<br><b>APRIL 18, 1883</b>   |  | 6. AGE (In years lost birthday)<br><b>84</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>PENNSYLVANIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GREATER BALTO. MEDICAL CENTER</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTO.</b>   |   | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>First <b>GEORGE</b> Middle <b>MARION</b> Last <b>LOUISA</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>LOUISA</b> Middle <b>COPPERSMITH</b> Last <b>COPPERSMITH</b>                    |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.<br><b>214 03 3723 D</b>   |   | 17. INFORMANT<br>Address <b>EMERG. Adm. sheet</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>aspiration</b><br>5609 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Intestinal obstruction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>1705</b> |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-3</b> <b>1968</b> , to <b>4-3</b> <b>1968</b> , that (I) (we) last saw the deceased alive on <b>4-3</b> <b>1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Liliana C. Baldonado</b>  |  |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>4/3/68</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>LILIA C. BALDONADO</b>  |  |  |   | 22e. ADDRESS<br><b>Q BMC</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4-6-1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md. Baltimore</b>                |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. COOK-PROCKTOWSON, Towson, Md.</b>   |  |  |   | 25a. REG'D BY REGISTRAR<br>DATE <b>APR 5 - 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>                                     |  |

MEDICAL CERTIFICATION

12130

0218

*Antarctic Distribution*

U.S. DEPT. OF AGRICULTURE

X 4/2/68  
B.M.C.

WILKINSON  
BALDWIN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MEDICAL CERTIFICATION

|   |  |  |   |  |   |   |  |  |   |  |
|---|--|--|---|--|---|---|--|--|---|--|
| 05188   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |   | CERTIFICATE OF DEATH   |   | 05192   |  |  |   |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Lottie May Bowen  |  |  | 2a. DATE OF DEATH Month 4 Day 19 Year 68  |  |   | 2b. HOUR 12 PM  |  |  |   |  |
| 3. SEX F  |  | 4. RACE Cau  |   | 5. DATE OF BIRTH 7-7-83  |   | 6. AGE (In years last birthday) 84 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |   |  |
| 7a. BIRTHPLACE (State or foreign country) Md  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.  |   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH Balto. Md.   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH Balto Co.   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GBMC |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY                      |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD  |  |  | 13b. COUNTY Balto   |  | 13c. CITY OR TOWN Balto   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER 17 Brightside Ave. |  |
| 14. FATHER'S NAME First Middle Last<br>Charles Marshall   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Sarah E Disney                      |  |   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No   |  |  | 16b. SOCIAL SECURITY NO. 217-40-2057  |  | 17. INFORMANT Family Address  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 250.0 DIABETIC ACIDOSIS - UREMIA<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |  |   |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>260X CARCINOMA OF BLADDER WITH EXTENSION  |  |  |   |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19                              |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-16, 1968 to 4-19, 1968, that (I) (we) last saw the deceased alive on 4-19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |   |   |  |  |   |  |
| 22b. SIGNATURE J. C. O'NEAL   |  |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |   | 22c. DATE SIGNED 4-19-68  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) C O'NEAL   |  |  |   | 22e. ADDRESS GBMC  |   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE 4/22/68  |   | 23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE   |   | 23d. LOCATION (City or Town) (County) (State) Pikesville Balto MD                                 |  |  |   |  |
| 24. FUNERAL DIRECTOR John S. Stensberg  |  |  |   | ADDRESS 6411 Windsor Mill Road Baltimore   |   | 25a. REC'D BY REGISTRAR DATE  |  | 25b. REGISTRAR'S SIGNATURE Charles Jones               |   |  |

APR 22 1968

RECEIVED 10 JANUARY 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (10)  
30M REV. 1/68

| M   |  |  |  | 05189  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |                             |  | 05193                       |  |  |  |
|---|--|--|--|--|--|--|--|---|--|-----------------------------|--|-----------------------------|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last  |  |  |  |  |  |  |  | 2a. DATE OF DEATH Month Day Year  |  |                             |  | 2b. HOUR M                  |  |  |  |
| Raymond J. Bowers   |  |  |  |  |  |  |  | 4/4/68  |  |                             |  | 4:48 P.                     |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |  |  | 6. AGE (In years lost birthday)   |  | IF UNDER 1 YEAR MONTHS DAYS |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |
| male  |  | white  |  | 12/15/96   |  |  |  | 71 YRS.   |  |                             |  |                             |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |   |  |                             |  |                             |  |  |  |
| Maryland  |  | U.S.A.   |  |  |  | Baltimore Md.  |  |   |  |                             |  |                             |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |                             |  |                             |  |  |  |
| Towson  |  | St Joseph Hosp.  |  | guard  |  | maritime   |  |   |  |                             |  |                             |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER  |  |                             |  |                             |  |  |  |
| Maryland  |  | Baltimore  |  |  |  |  |  | 3039 East Ave   |  |                             |  |                             |  |  |  |
| 14. FATHER'S NAME First Middle Last   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |  |  |  |   |  |                             |  |                             |  |  |  |
| Unknown   |  |  |  | Unknown  |  |  |  |   |  |                             |  |                             |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address   |  |                             |  |                             |  |  |  |
| Yes   |  | WWI  |  | 706-12-6015  |  | Cordelia B. Towson   |  | 3039 East Ave   |  |                             |  |                             |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                |  |                             |  |                             |  |  |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis  |  |  |  |  |  |  |  | acute   |  |                             |  |                             |  |  |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |   |  |                             |  |                             |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  | (b) DUE TO, OR AS A CONSEQUENCE OF  |  |                             |  |                             |  |  |  |
|   |  |  |  |  |  |  |  | (c)   |  |                             |  |                             |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |  |                             |  |                             |  |  |  |
| 4201  |  |  |  |  |  |  |  |   |  |                             |  |                             |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |  |                             |  |                             |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |                             |  |                             |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |  |                             |  |                             |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/4/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE Christopher Mandelis  |  | DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  | 22c. DATE SIGNED 4/5/68  |  |   |  |                             |  |                             |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |  |  |  |  |   |  |                             |  |                             |  |  |  |
| Christopher Mandelis  |  | 2308 Edmondson Ave.  |  |  |  |  |  |   |  |                             |  |                             |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |   |  |                             |  |                             |  |  |  |
| Burial  |  | 4/8/68   |  | Loudon National Cem.   |  | Baltimore Maryland   |  |   |  |                             |  |                             |  |  |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR DATE   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                             |  |                             |  |  |  |
| Ambrose Inc.  |  | 1328 Sulphur Sq. Rd.   |  | APR 9 - 1968   |  | [Signature]  |  |   |  |                             |  |                             |  |  |  |

1513

03:30

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05194

|  |  |   |  |   |  |   |  |  |  |                               |  |
|--|--|---|--|---|--|---|--|--|--|-------------------------------|--|
| 1. DECEASED NAME<br>(Type or print)  |  | First   |  | Middle  |  | Last  |  | 2a. DATE OF DEATH  |  | 2b. HOUR                      |  |
| DANIEL   |  | EDWARD  |  | BRATKOWSKI  |  |   |  | Month Day Year<br>APRIL 27, 1968   |  | 3:30A M                       |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN |  |
| MALE   |  | WHITE   |  | 2/2/24  |  | 44 YRS.   |  |  |  |                               |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |  |                               |  |
| MARYLAND   |  | U.S.A.  |  |   |  | BALTIMORE   |  |  |  | Md.                           |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |                               |  |
| FORT HOWARD  |  | VETERANS ADMIN. HOSPITAL  |  | CLERICAL  |  | FED. GOVERN.  |  |  |  |                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |                               |  |
| MARYLAND   |  |   |  | BALTIMORE   |  |   |  | 3418 LEVERTON AVENUE   |  |                               |  |
| 14. FATHER'S NAME First  |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME First  |  | Middle   |  | Last                          |  |
| STANLEY  |  | -   |  | BRATKOWSKI  |  | MARY  |  | GUZINSKA   |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | Address   |  |  |  |                               |  |
| YES WWII   |  | 216 18 98 55  |  | CLINICAL RECORDS, VAH, FORT HOWARD, MD.   |  |   |  |  |  |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HEPATIC COMA</u><br><u>571.9</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CIRRHOSIS OF LIVER</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>DAYS</u><br><u>YEARS</u> |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>5810</u>  |  |   |  |   |  |   |  |  |  |                               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? YES                     |  |  |  |                               |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |                               |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County   |  | State                         |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>APR 22, 1968</u> , to <u>APR 27, 1968</u> , that (X) (we) last<br>saw the deceased alive on <u>APR 27, 1968</u> , and that in (X) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (X) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |                               |  |
| 22b. SIGNATURE   |  | DEGREE  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED  |  |  |  |                               |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <u>MARIO J. QUIROS, M.D.</u>   |  |   |  | 22e. ADDRESS<br><u>VAH, FT. HOWARD, MD.</u>   |  |   |  |  |  |                               |  |
| 23a. BURIAL CREMATION<br>REMOVAL (Specify)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |                               |  |
| Burial   |  | May 1 - 68  |  | Balt. Nat. Cem  |  | 5500 Fred. Rd.  |  |  |  |                               |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |                               |  |
| FISHER FUNERAL HOME  |  | 1930 EASTERN AVE.,<br>BALTIMORE, MD.  |  | MAY 1 1968  |  | Charles Judge   |  |  |  |                               |  |

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Journal of Management Inquiry 22(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |                         |   |  |   |   |   |
|--|-------------------------|---|--|---|---|---|
| 05191  |                         | 05195   |  |   |   |   |
| 1. DECEASED-NAME<br>(Type or print)<br><b>EDNA J. BREYER</b>   |                         | 2a. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>12</b> Year <b>1968</b>                                      |  | 2b. HOUR<br><b>11:30</b> A. M.  |   |   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br><b>FEBRUARY 19, 1884</b>  |  | 6. AGE (In years<br>lost birthday)<br><b>84</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>MARYLAND</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |
| 10. CITY OR TOWN OF DEATH<br><b>RODGERS FORGE</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>218 OVERBROOK RD.</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>SALESLADY</b>  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>DEPT. STORE</b>                                      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>MARYLAND</b>  |                         | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>218 OVERBROOK RD.</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>First Middle Last<br><b>HORNEY</b>  |                         | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>UNKNOWN</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>                                     |   |   |
| 16b. SOCIAL SECURITY NO.<br><b>214-26-9387</b>   |                         | 17. INFORMANT<br><b>MR. EDMUND G. BETZ</b>  |  | Address<br><b>SAME</b>  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio - Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hodgkins Disease - Generalized</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypertensive - Arteriosclerotic CHD</b><br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH           |                         |   |  |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>201 X</b>  |                         |   |  |   |   |   |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |                         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                             |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 7, 1949</b> to <b>Apr 12, 1968</b> , that (I) ( <del>we</del> ) last<br>saw the deceased alive on <b>Apr 12, 1968</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the<br>causes stated above, (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death. |                         |   |  |   |   |   |
| 22b. SIGNATURE<br><b>Willard Applefeld</b>   |                         | DEGREE<br><b>MD</b>   |  | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>                       |   | 22c. DATE SIGNED<br><b>4/13/68</b>  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>WILLARD APPLEFELD</b>  |                         | 22e. ADDRESS<br><b>6615 REISTERSTOWN RD. BALTIMORE, MD.</b>   |  |   |   |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>4/15/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MD.</b>                          |
| 24. FUNERAL DIRECTOR<br><b>MITCHELL WIEDEFELD HOME, INC.</b><br><b>6500 YORK RD. BALTIMORE, MD.</b>  |                         | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 16 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |

1. Name of Deceased: [illegible]  
2. Date of Death: [illegible]  
3. Place of Death: [illegible]  
4. Cause of Death: [illegible]  
5. Name of Physician: [illegible]  
6. Name of Coroner: [illegible]  
7. Name of Undertaker: [illegible]  
8. Name of Burial Place: [illegible]  
9. Name of Burial Place: [illegible]  
10. Name of Burial Place: [illegible]

11. Name of Burial Place: [illegible]  
12. Name of Burial Place: [illegible]  
13. Name of Burial Place: [illegible]  
14. Name of Burial Place: [illegible]  
15. Name of Burial Place: [illegible]  
16. Name of Burial Place: [illegible]  
17. Name of Burial Place: [illegible]  
18. Name of Burial Place: [illegible]  
19. Name of Burial Place: [illegible]  
20. Name of Burial Place: [illegible]

21. Name of Burial Place: [illegible]  
22. Name of Burial Place: [illegible]  
23. Name of Burial Place: [illegible]  
24. Name of Burial Place: [illegible]  
25. Name of Burial Place: [illegible]  
26. Name of Burial Place: [illegible]  
27. Name of Burial Place: [illegible]  
28. Name of Burial Place: [illegible]  
29. Name of Burial Place: [illegible]  
30. Name of Burial Place: [illegible]

31. Name of Burial Place: [illegible]  
32. Name of Burial Place: [illegible]  
33. Name of Burial Place: [illegible]  
34. Name of Burial Place: [illegible]  
35. Name of Burial Place: [illegible]  
36. Name of Burial Place: [illegible]  
37. Name of Burial Place: [illegible]  
38. Name of Burial Place: [illegible]  
39. Name of Burial Place: [illegible]  
40. Name of Burial Place: [illegible]



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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)<br><b>Grace</b>  |  |  | First<br><b>May</b>  |  |  | Middle<br><b>Brown</b>  |  |  | Last<br><b>Brown</b>   |  |  | 2a. DATE OF DEATH<br>Month<br><b>April</b> Day<br><b>23</b> Year<br><b>1968</b> |  |  | 2b. HOUR<br><b>7:20</b> a. <b>M</b>                    |  |  |
| 3. SEX<br><b>female</b>  |  |  | 4. RACE<br><b>white</b>  |  |  | 5. DATE OF BIRTH<br><b>Sept. 23, 1892</b>   |  |  | 6. AGE (In years<br>last birthday)<br><b>75</b> YRS.                                 |  |  | IF UNDER 1 YEAR<br>MONTHS<br><b>0</b> DAYS<br><b>0</b>                          |  |  | IF UNDER 24 HRS.<br>HOURS<br><b>0</b> MIN.<br><b>0</b> |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Md.</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  | Md.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>SPRING GROVE STATE HOSP.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>housewife</b>  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |  |   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Balto.</b>   |  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>1527 W. Lombard St.</b>                            |  |  |  |  |  |
| 14. FATHER'S NAME<br><b>Joseph Kidd</b>  |  |  | First<br><b>Joseph</b> Middle<br><b>Kidd</b> Last<br><b>Kidd</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Mary E. Stupp</b>  |  |  | First<br><b>Mary</b> Middle<br><b>E.</b> Last<br><b>Stupp</b>                        |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>  |  |  | 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>  |  |  | Address  |  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction, acute, death</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. <b>4201</b><br>(b) <b>Arteriosclerotic Cardiovascular Ht. Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerosis, Generalized, senile</b><br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 min.</b><br><b>20 years</b><br><b>20 years</b> |  |  |  |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Mitral Stenosis with atrial fibrillation, 20 years or more.</b>   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?              |  |  |   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                    |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |   |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 5</b> , 19 <b>37</b> , to <b>April 23</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last<br>saw the deceased alive on <b>April 23</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (and) (did not) view the body after death.   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Anthony J. Young, M.D.</b>  |  |  | 22c. DATE SIGNED<br><b>4-23-68</b>   |  |  | 22d. PHYSICIAN'S<br>NAME (Type)<br><b>Anthony J. Young, M.D.</b>  |  |  | 22e. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>     |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>Apr. 26-1968</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Frederick, Md. 21701</b>         |  |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>R. W. Kneeney</b><br><b>M. R. Etchison &amp; Son</b>  |  |  | 24a. ADDRESS<br><b>Frederick, Md.</b><br><b>100 E. Church St.</b>  |  |  | 25a. RECEIVED BY REGISTRAR<br><b>APR 26 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                   |  |  |   |  |  |  |  |  |

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is divided into two main sections: the first section deals with the general situation and the second section deals with the progress of the work.

2. The second part of the report deals with the results of the work during the year. It is divided into two main sections: the first section deals with the results of the work in the field and the second section deals with the results of the work in the laboratory.

3. The third part of the report deals with the conclusions of the work during the year. It is divided into two main sections: the first section deals with the conclusions of the work in the field and the second section deals with the conclusions of the work in the laboratory.

4. The fourth part of the report deals with the recommendations of the work during the year. It is divided into two main sections: the first section deals with the recommendations of the work in the field and the second section deals with the recommendations of the work in the laboratory.

5. The fifth part of the report deals with the summary of the work during the year. It is divided into two main sections: the first section deals with the summary of the work in the field and the second section deals with the summary of the work in the laboratory.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Rhoda Chairs Brown  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>April 23 1968           |   |  | 2b. HOUR A<br>9:50 M  |  |  |  |
| 3. SEX<br>female   |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>Sept. 11, 1895  |  | 6. AGE (In years last birthday)<br>72 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>AnneArundelCty, Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson, Maryland  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Dulaney Towson Nursing Home |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br>housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Timonium   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER<br>1912 Pot Spring Road                   |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Samuel Chairs  |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Annie Linsted |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service) |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>212-28-7851  |  | 17. INFORMANT<br>Address<br>Dulaney Towson Nursing Home, 111 West Road 21204                                |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>443X</u><br>(b) <u>Hypertensive vascular dis.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>—</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 weeks</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><u>Peripheral embolus of leg.</u> |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 1968  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 19 68</u> to <u>April 23 1968</u> , that (I) (we) last saw the deceased alive on <u>4/23 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Christian Mass M.D.</u>   |  | 22c. DATE SIGNED<br><u>4/24/68</u>  |  | 22d. PHYSICIAN'S NAME (Type)<br>Dr. Christian Mass  |  |   |  |  |  |
| 22e. ADDRESS<br>Balto. Nat. Pike & St. Johns' Lane   |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>4/26/68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn  |  | 23d. LOCATION (City or Town) (County) (State)<br>Woodlawn, Balto. Co., Md.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>H.W. Jenkins & Sons Co.  |  | 24a. ADDRESS<br>1905 York Rd.<br>Balto. 12, Md.   |  | 25a. REC'D BY REGISTRAR<br>DATE<br>APR 25 1968  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

|   |  |  |  |
|---|--|--|--|
| 05194   |  | 05198  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Charles</b>  |  | First <b>S</b> Middle <b>C</b> Last <b>A R O</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Italy</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. JOSEPH HOSPITAL</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  |
| 14. FATHER'S NAME<br><b>John Caro</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Catherine Bianca</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Mrs. Rose D. Caro- Same</b>   |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive Intestinal Infarction</b><br><b>444.2</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Thrombosis of superior mesenteric artery</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>570.2</b><br><b>Recurrent Myocardial Infarction</b>   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  | 21d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/8/</b> , 19 <b>68</b> , to <b>4/24/</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/24/</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |
| 22b. SIGNATURE<br><b>Reynaldo Orjuela Gomez, M.D.</b>   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/29/68</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. 5305 Harford Rd.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 25 1968</b>   |  |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A-15 (4)  
30M REV. 1/68

| 05195  |  |  |  |  |  |  |  |  |  | 05199  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |  | First Middle Last  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  | 2b. HOUR   |  |  |  |  |
| JEROME FRANCIS CARTER  |  |  |  |  |  |  |  |  |  | APRIL 20, 1968   |  |  |  |  | 1:30A M  |  |  |  |  |
| 3. SEX   |  |  |  |  | 4. RACE  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  |
| MALE   |  |  |  |  | WHITE  |  |  |  |  | 10/8/95  |  |  |  |  | 72 YRS.  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |
| MARYLAND   |  |  |  |  | U.S.A.   |  |  |  |  |  |  |  |  |  | BALTIMORE Md.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |
| FORT HOWARD  |  |  |  |  | VETERANS ADMIN. HOSPITAL   |  |  |  |  | MECHANIC   |  |  |  |  | AUTOMOBILE   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| MARYLAND   |  |  |  |  |  |  |  |  |  | BALTIMORE  |  |  |  |  | 710 PURITAN STREET   |  |  |  |  |
| 14. FATHER'S NAME First Middle Last  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| JEROME FRANCIS CARTER  |  |  |  |  | KATHERINE M. SIDE  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT  |  |  |  |  | Address  |  |  |  |  |
| YES  |  |  |  |  | 217 12 07 20   |  |  |  |  | CLINICAL RECORDS, VAH, FT. HOWARD, MD.   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>4129 Congestive Heart Failure</u>   |  |  |  |  |  |  |  |  |  | Recent   |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| (b) <u>Arteriosclerotic Heart Disease</u>  |  |  |  |  |  |  |  |  |  | Unknown  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| (c)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 4200   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from <u>APRIL 12, 1968</u> , to <u>APRIL 20 1968</u> , that <del>he</del> (we) last saw the deceased alive on <u>APRIL 20, 19</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>not</del> view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <u>Isabelita Y. Cordoba M.D.</u>  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED <u>4 20 68</u>  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>ISABELITA Y. CORDOBA, M. D.</u>  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS <u>VAH, FORT HOWARD, MD.</u>  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |
| BURIAL   |  |  |  |  | April 23, 1968   |  |  |  |  | PROSPECT HILL CEMETERY   |  |  |  |  | Towson, Maryland   |  |  |  |  |
| WM. COOK FUNERAL HOME  |  |  |  |  | Towson   |  |  |  |  | 1055 YORK RD. BALTIMORE 04, MD   |  |  |  |  | 25a. REC'D BY REGISTRAR, DATE <u>APR 23 1968</u>   |  |  |  |  |
| BROOKS FUNERAL SERVICE   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 4-68

MD  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05196

05200

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>AGNES REBECCA CARVER</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>12</b> Year <b>68</b> |  |  | 2b. HOUR<br><b>6:45 PM</b>   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>CAU.</b>  |  | 5. DATE OF BIRTH<br><b>6-15-90</b>   |  | 6. AGE (In years lost birthday)<br><b>77</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTO. TOWSON Md.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GREATER BALTIMORE MEDICAL CENTER</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Cornelius BAUBITZ</b>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>UNKN GILL</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)<br><b>UNKN</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-50-6026</b>  |  | 17. INFORMANT<br><b>PATIENTS CHART</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pulmonary Embolism.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>myocardial ischemia</b>   |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>a few minutes</b><br><b>a few minutes</b><br><b>several days.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>intestinal obstruction, myocardial ischemia</b>  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-8</b> , 19 <b>68</b> , to <b>4-12</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-12</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                                 |  | 22c. DATE SIGNED<br><b>4-12-68</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>A. Collado, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>6701 NORTH CHARLES ST</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>April 15, 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Carrolls Chapel Cem.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. County, Md.</b>                   |  |
| 24. FUNERAL DIRECTOR<br><b>A. J. Schhardt</b>   |  |   |  | ADDRESS<br><b>Owings Mills, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 15 1968</b>   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                   |  |  |  |  |  |              |   |  |   |  |  |                    |  |  |  |  |
|--|--|--|-------------------|--|--|--|--|--|--------------|---|--|---|--|--|--------------------|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |                   |  |  |  |  |  |              |   |  |   |  |  |                    |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or Print)  |  |  | First<br>VIRGINIA |  |  | Middle<br>IRENE  |  |  | Last<br>CASS |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 19 68 |  |  | 2b. HOUR<br>M 8:00 |  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |                   | 5. DATE OF BIRTH<br>4-19-1965  |  | 6. AGE (In years last birthday)<br>3 YRS.                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |              | IF UNDER 24 HRS.<br>HOURS MIN                                   |  | 2c. DATE PRONOUNCED DEAD<br>Month April Day 25 Year 19 68                                     |  |  | 2d. HOUR<br>M 8:00 |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Chicago Hgts., Ill.   |  |  |                   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |              |   |  | 9. COUNTY OF DEATH<br>BALTIMORE Md.   |  |  |                    |  |  |  |  |
| 1d. CITY OR TOWN OF DEATH<br>Lutherville   |  |  |                   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>1005 Adcock Road |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |              |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |                    |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  |  |                   | 13b. COUNTY<br>Baltimore   |  |  |  | 13c. CITY OR TOWN<br>Lutherville   |              |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |                    | 13e. STREET AND NUMBER<br>1005 Adcock Road |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Wade Cass  |  |  |                   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Carol Adams |  |  |              |   |  |   |  |  |                    |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No  |  |  |                   | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>-----                       |  |  |  | 17. INFORMANT<br>Never Had one   |              |   |  | ADDRESS<br>Wade Cass 1005 Adcock Rd., Lutherville, Md.  |  |  |                    |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Epilepsy</u><br>3459<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |                   |  |  |  |  |  |              |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |                    |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>3533  |  |  |                   |  |  |  |  |  |              |   |  |   |  |  |                    |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |                   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?            |  |  |              |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |  |                    |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |                   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |              |   |  |   |  |  |                    |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                   |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State |  |  |              |   |  |   |  |  |                    |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |                   |  |  |  |  |  |              |   |  |   |  |  |                    |  |  |  |  |
| ACTUAL SIGNATURE<br>Charles S. Springate   |  |  |                   | M.D.<br>Charles S. Springate, M.D.   |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |              |   |  | 22b. DATE SIGNED<br>April 25, 1968  |  |  |                    |  |  |  |  |
| EXAMINER'S NAME (Type)   |  |  |                   |  |  |  |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>   |              |   |  |   |  |  |                    |  |  |  |  |
|  |  |  |                   |  |  |  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |              |   |  |   |  |  |                    |  |  |  |  |
|  |  |  |                   |  |  |  |  | ADDRESS (Street, city, town, or county)  |              |   |  |   |  |  |                    |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  |                   | 23b. DATE<br>4-27-1968   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lakewood Park Cem.     |  |  |              | 23d. LOCATION (City or Town) (County) (State)<br>Westlake, Ohio |  |   |  |  |                    |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks, Towson, Inc. Towson, Md.  |  |  |                   |  |  | 25a. REC'D BY REGISTRAR<br>DATE APR 29 1968                  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |              |   |  |   |  |  |                    |  |  |  |  |

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OFFICE OF THE ATTORNEY GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 374  
30M REV. 7-58

| MARYLAND STATE DEPARTMENT OF HEALTH   |         |  |  |  |  |  |  |
|---|---------|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |  |  |  |  |  |  |
| CERTIFICATE OF DEATH  |         |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |         | First Middle Last  |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| George W. Champness   |         |  |  | Month Day Year<br>April 13 68  |  | 6.15 PM  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                      |  |
| Male  | White   | 4-7-1886   |  | 82 YRS.  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |
| Maryland  |         | U.S.A.   |  |  |  | Baltimore Md.  |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Towson  |         | St. Joseph Hospital  |  | Retired  |  | Insurance  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| Maryland  |         | - Baltimore  |  | 13e. STREET AND NUMBER   |  |  |  |
| 14. FATHER'S NAME First Middle Last   |         | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO.   |  |
| Thomas W. Champness   |         | Mary Lewald  |  | No   |  | 4201   |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |         | 17b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | 2208   |  |
| No  |         | 4201   |  | Kennard F. Champness: 2208   |  | 2208   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)    |  | 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                    |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109   |         | DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardio-vascular disease. |  | DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral vascular thrombosis  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.  |         |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)  |         | 4201   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |         | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/4/1968, to 4/13/1968, that (I) (we) last saw the deceased alive on 4/13/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         | 22b. SIGNATURE Samuel Lee, M.D.  |  | 22c. DATE SIGNED 4-14-68   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |         | 22e. ADDRESS   |  | 22f. ADDRESS   |  |  |  |
| Samuel Lee, M.D.  |         | 7620 York Rd., Towson, Md., 21204  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |
| Burial  |         | 4-17-68  |  | Holy Redeemer Cemetery   |  | 4430 Belair Rd., Balto., Md.   |  |
| 24. FUNERAL DIRECTOR  |         | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| Charles J. Jailer   |         | 901 S. Conkling St. Baltimore, 21224, Md.                                    |  | DATE APR 18 1968   |  | Charles J. Jailer  |  |

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UNITED STATES OF AMERICA

Department of Justice

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item#24, File#101 8/17/68  
05199  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05203

|  |         |  |        |   |   |   |                          |   |            |  |
|--|---------|--|--------|---|---|---|--------------------------|---|------------|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         | First  | Middle | Lost  | 2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI-DEATH MATED <input type="checkbox"/> |   | Month                    | Day   | Year       | 2b. HOUR                                     |
| DONALD   |         |  |        | CHAPPLE JR  |   |   |                          |   | 19         | M  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (In years last birthday)   | IF UNDER 1 YEAR   | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD |   | Month      | Day  |
| Male   | Negro   | Jan 27-67  |        | YRS. 152  | MONTHS  | DAYS  | April 24                 |   | Year 19 68 | 2d. HOUR 9:30 PM                             |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |                          | M.D.  |            |  |
| Baltimore  |         | USA  |        |   |   | BALTIMORE   |                          |   |            |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                          | 12b. KIND OF BUSINESS OR INDUSTRY                                   |            |  |
| Baltimore  |         | St. Joseph Hospital  |        |   |   |   |                          |   |            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         | 13b. COUNTY  |        | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?  |                          | 13e. STREET AND NUMBER  |            |  |
| Md.  |         |  |        | Baltimore   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |                          | 716 Mc Cabe Avenue  |            |  |
| 14. FATHER'S NAME  |         | First  | Middle | Lost  | 15. MOTHER'S MAIDEN NAME  |   | First                    | Middle  | Lost       |  |
| Donald Chapple Sr  |         |  |        |   | Cecelyn Chapple   |   |                          |   |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT   |   | ADDRESS   |                          |   |            |  |
| No   |         |  |        | Donald Chapple Sr   |   |   |                          |   |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |         |  |        |   |   |   |                          |   |            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Asphyxia   |         |  |        |   |   |   |                          |   |            |  |
| 890X DUE TO, OR AS A CONSEQUENCE OF  |         |  |        |   |   |   |                          |   |            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carbon monoxide   |         |  |        |   |   |   |                          |   |            |  |
| (c) Conflagration  |         |  |        |   |   |   |                          |   |            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |         |  |        |   |   |   |                          |   |            |  |
| 9160   |         |  |        |   |   |   |                          |   |            |  |
| 19a. DATE OF OPERATION   |         |  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |                          | 20. AUTOPSY?  |            |  |
|  |         |  |        |   |   |   |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |            |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |         | 21b. TIME OF INJURY Month, Day, Year   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |                          |   |            |  |
|  |         | 8:55 P.M. 4-24 19 68   |        | Undetermined  |   |   |                          |   |            |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |        | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |                          | County  |            | State  |
|  |         | home   |        | 716 Mc Cabe Ave.  |   | Baltimore   |                          |   |            | Md.  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |         |  |        |   |   |   |                          |   |            |  |
| ACTUAL SIGNATURE   |         |  |        | Charles S. Springate, M.D.  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                          | 22b. DATE SIGNED  |            |  |
| EXAMINER'S NAME (Type)   |         |  |        |   |   | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                          |                          | April 25, 1968  |            |  |
|  |         |  |        |   |   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |                          | ADDRESS (Street, city, town, or county)                             |            |  |
|  |         |  |        |   |   |   |                          |   |            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town)  |                          | (County)  |            | (State)                                      |
| Burial   |         | 4-27-68  |        | Mt Auburn Cem   |   | Baltimore   |                          |   |            |  |
| 24. FUNERAL DIRECTOR   |         |  |        | ADDRESS   |   | 25a. REC'D BY REGISTRAR   |                          | 25b. REGISTRAR'S SIGNATURE  |            |  |
| William-Cook, Brooks, York Road,   |         |  |        | Towson, Md. 21204   |   | DATE APR 26 1968  |                          | [Signature]   |            |  |

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UNITED STATES DEPARTMENT OF AGRICULTURE

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| GENERAL INFORMATION |          | CULTURAL DATA |         | ANALYTICAL DATA |        |
|---------------------|----------|---------------|---------|-----------------|--------|
| DATE                | LOCATION | CROP          | VARIETY | TEST            | RESULT |
| 1911                | ...      | ...           | ...     | ...             | ...    |
| 1912                | ...      | ...           | ...     | ...             | ...    |
| 1913                | ...      | ...           | ...     | ...             | ...    |
| 1914                | ...      | ...           | ...     | ...             | ...    |
| 1915                | ...      | ...           | ...     | ...             | ...    |
| 1916                | ...      | ...           | ...     | ...             | ...    |
| 1917                | ...      | ...           | ...     | ...             | ...    |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (Rev. 1-68)  
30M REV. 1-68

| 05200   |  |  |         |  |  |                  |  |  |                                 | 05204  |  |                       |  |  |  |  |  |  |  |                        |  |  |  |  |
|---|--|--|---------|--|--|------------------|--|--|---------------------------------|--|--|-----------------------|--|--|--|--|--|--|--|------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |         |  |  |                  |  |  |                                 | CERTIFICATE OF DEATH   |  |                       |  |  |  |  |  |  |  |                        |  |  |  |  |
| 1. DECEASED-NAME (Type or print)  |  |  |         |  | First Middle Last  |                  |  |  |                                 | 2a. DATE OF DEATH  |  |                       |  |  | 2b. HOUR   |  |  |  |  |                        |  |  |  |  |
| Merab Cecelia Clark   |  |  |         |  |  |                  |  |  |                                 | Month Day Year<br>April 13 1968  |  |                       |  |  | 5:30PM   |  |  |  |  |                        |  |  |  |  |
| 3. SEX  |  |  | 4. RACE |  |  | 5. DATE OF BIRTH |  |  | 6. AGE (In years last birthday) |  |  | IF UNDER 1 YEAR       |  |  | IF UNDER 24 HRS.   |  |  |  |  |                        |  |  |  |  |
| Female  |  |  | White   |  |  | April 5, 1925    |  |  | 43 YRS.                         |  |  | MONTHS DAYS HOURS MIN |  |  |  |  |  |  |  |                        |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?   |                  |  |  |                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                       |  |  | 9. COUNTY OF DEATH   |  |  |  |  |                        |  |  |  |  |
| Maryland  |  |  |         |  | U.S.A.   |                  |  |  |                                 |  |  |                       |  |  | Baltimore Md.  |  |  |  |  |                        |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  |  |  |                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |                       |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                        |  |  |  |  |
| Reisterstown  |  |  |         |  | 313 Cherry Hill Rd   |                  |  |  |                                 | Secretary  |  |                       |  |  | Railroad   |  |  |  |  |                        |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |         |  | 13b. COUNTY  |                  |  |  |                                 | 13c. CITY OR TOWN  |  |                       |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER |  |  |  |  |
| Maryland  |  |  |         |  | Baltimore  |                  |  |  |                                 | Reisterstown   |  |                       |  |  | X 313 Cherry Hill Rd.  |  |  |  |  |                        |  |  |  |  |
| 14. FATHER'S NAME   |  |  |         |  | 15. MOTHER'S MAIDEN NAME   |                  |  |  |                                 |  |  |                       |  |  |  |  |  |  |  |                        |  |  |  |  |
| First Middle Last   |  |  |         |  | First Middle Last  |                  |  |  |                                 |  |  |                       |  |  |  |  |  |  |  |                        |  |  |  |  |
| Thomas Benjemin Small   |  |  |         |  | Asenath Elizabeth Parker   |                  |  |  |                                 |  |  |                       |  |  |  |  |  |  |  |                        |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  |  |         |  | 16b. SOCIAL SECURITY NO.   |                  |  |  |                                 | 17. INFORMANT  |  |                       |  |  | Address  |  |  |  |  |                        |  |  |  |  |
| No  |  |  |         |  | 220-18-7217  |                  |  |  |                                 | Maynard E. Clark   |  |                       |  |  | 313 Cherry Hill Rd. Reisterstown, Md.  |  |  |  |  |                        |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Generalized Carcinomatosis<br>174X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Carcinoma rt. breast<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>21 mos.<br>4 yrs. |  |  |         |  |  |                  |  |  |                                 |  |  |                       |  |  |  |  |  |  |  |                        |  |  |  |  |
|   |  |  |         |  |  |                  |  |  |                                 |  |  |                       |  |  |  |  |  |  |  |                        |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>170X  |  |  |         |  |  |                  |  |  |                                 |  |  |                       |  |  |  |  |  |  |  |                        |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  |  |  |                                 | 20a. AUTOPSY?  |  |                       |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |                        |  |  |  |  |
| 8-18-64   |  |  |         |  | Ca. rt. breast   |                  |  |  |                                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                       |  |  |  |  |  |  |  |                        |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |         |  | 21b. TIME OF INJURY  |                  |  |  |                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |                       |  |  |  |  |  |  |  |                        |  |  |  |  |
|   |  |  |         |  | HOUR A.M. Month Day Year<br>P.M. 19  |                  |  |  |                                 |  |  |                       |  |  |  |  |  |  |  |                        |  |  |  |  |
| 21d. INJURY OCCURRED  |  |  |         |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  |  |  |                                 | 21f. LOCATION  |  |                       |  |  | City or Town County State  |  |  |  |  |                        |  |  |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |         |  |  |                  |  |  |                                 | Street or R.F.D. No.   |  |                       |  |  |  |  |  |  |  |                        |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-16-63, 19__, to 4-13-68, 19__, that (I) (we) lost saw the deceased alive on 4-11-68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |         |  |  |                  |  |  |                                 |  |  |                       |  |  |  |  |  |  |  |                        |  |  |  |  |
| 22b. SIGNATURE  |  |  |         |  |  |                  |  |  |                                 | 22c. DATE SIGNED   |  |                       |  |  |  |  |  |  |  |                        |  |  |  |  |
| D. D. Caples M.D.   |  |  |         |  |  |                  |  |  |                                 | 4-15-68  |  |                       |  |  |  |  |  |  |  |                        |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |         |  |  |                  |  |  |                                 | 22e. ADDRESS   |  |                       |  |  |  |  |  |  |  |                        |  |  |  |  |
| D. D. Caples, M. D.   |  |  |         |  |  |                  |  |  |                                 | 6 Hanover Rd., Reisterstown, Md. 21136   |  |                       |  |  |  |  |  |  |  |                        |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |         |  | 23b. DATE  |                  |  |  |                                 | 23c. NAME OF CEMETERY OR CREMATORY   |  |                       |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |                        |  |  |  |  |
| Burial  |  |  |         |  | April 16, 1968   |                  |  |  |                                 | Druid Ridge Cemetery Pikesville, Balto., Md.   |  |                       |  |  |  |  |  |  |  |                        |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |         |  |  |                  |  |  |                                 | 25a. REC'D BY REGISTRAR  |  |                       |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |                        |  |  |  |  |
| H. J. Echhardt  |  |  |         |  |  |                  |  |  |                                 | Owings Mills, Md.  |  |                       |  |  | DATE April 16 1968 Charles Judge   |  |  |  |  |                        |  |  |  |  |

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05202

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #5 & 6 Film #G390 4/11/68

CERTIFICATE OF DEATH

05205

|  |  |   |   |   |   |  |   |   |  |   |
|--|--|---|---|---|---|--|---|---|--|---|
| 1. DECEASED-NAME<br>(Type or print) <b>Henry Clardy</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>6</b> Year <b>68</b>   |   |   | 2b. HOUR<br><b>2:25 PM</b>   |   |   |  |   |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>                       |   | 5. DATE OF BIRTH<br><b>July 10 - 1904</b>   |   | 6. AGE (In years last birthday)<br><b>63</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.  |  |   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore Co. Md.</b>   |   |   |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Rondallstown</b>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Baltimore Gen Hosp</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Molder</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hopewell Co.</b> |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Bere Rd</b>   |  |   | 13b. COUNTY<br><b>Balt Co.</b>  |   | 13c. CITY OR TOWN                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>2934 Bere Rd.</b>           |   |
| 14. FATHER'S NAME First <b>John</b> Middle <b>Clardy</b> Last  |  |   |   | 15. MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b>Booger</b> Last  |   |  |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown  |  |   | 16b. SOCIAL SECURITY NO.<br><b>220.05-9997</b>  |   |   | 17. INFORMANT<br><b>Mrs Anna A Clardy</b>  |   |   | Address<br><b>2934 Bere Rd</b>                           |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Terminal Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinomatosis, stomach</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>1519</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>1518</b>  |  |   |   |   |   |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                          |   |   |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-20</b> , 19 <b>65</b> , to <b>4-6</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-6</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                   |  |   |   |   |   |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Antonio R. Jan</b>  |  |   |   |   |   | DEGREE<br><b>MD</b>  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4-6-68</b>                   |
| 22d. PHYSICIAN'S NAME (Type)   |  |   |   |   |   | 22e. ADDRESS   |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>Apr 10-68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>London St.</b> |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md</b>  |  |   |
| 24. FUNERAL DIRECTOR<br><b>Thos J. Henry Inc.</b>  |  |   |   |   |   | ADDRESS<br><b>1600 Holliston St</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 11 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. ...</b> |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |         |  |        |   |                         |  |                 |   |                          |  |
|---|---------|--|--------|---|-------------------------|--|-----------------|---|--------------------------|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First  | Middle | Lost  | 2a. DATE KNOWN OF DEATH |  | Month           | Day                                     | Year                     | 2b. HOUR                                     |
| Carl  |         | C.   |        | Class   | April 28                |  | 19              | 68                                      | 3 PM                     | M  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (In years last birthday)   | IF UNDER 1 YEAR         |  | IF UNDER 24 HRS |   | 2c. DATE PRONOUNCED DEAD |  |
| Male  | Cau.    | 6-30-1913  |        | 51 YRS.   | MONTHS DAYS             |  | HOURS MIN.      |   | April 28 1968 3 PM       |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |                         | 9. COUNTY OF DEATH   |                 | Md.                                     |                          |  |
| Baltimore Co.   |         | U.S.A.   |        | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                      |                         | Baltimore  |                 |   |                          |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                         | 12b. KIND OF BUSINESS OR INDUSTRY  |                 |   |                          |  |
| Towson  |         | St. Joseph's   |        | Manager   |                         | Essex Lumber   |                 |   |                          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |        | 13c. CITY OR TOWN   |                         | 13d. INSIDE CITY LIMITS?   |                 | 13e. STREET AND NUMBER                  |                          |  |
| Md.   |         | Baltimore  |        | Parkville   |                         | YES <input type="checkbox"/> NO <input type="checkbox"/>                         |                 | 21234                                   |                          |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)                      |                         | 16b. SOCIAL SECURITY NO.   |                 | 17. INFORMANT                           |                          | ADDRESS                                      |
| Charles Frederick Class   |         | Goldie Deise   |        | No  |                         | 217-05-1972  |                 | Mrs Jerryleen A. Class                  |                          | 21234 Woodside Avenue                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion Sudden</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary Insufficiency</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>2+ yrs</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |         |  |        |   |                         |  |                 |   |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>4201</u>  |         |  |        |   |                         |  |                 |   |                          |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |        |   |                         | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 |   |                          |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M.                    |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |                         |  |                 |   |                          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |                         |  |                 |   |                          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Notatural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |        |   |                         |  |                 |   |                          |  |
| ACTUAL SIGNATURE  |         | Charles F. O'Donnell, M.D.   |        |   |                         | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                  |                 | 22b. DATE SIGNED                        |                          |  |
| EXAMINER'S NAME (Type)  |         | Charles F. O'Donnell, M.D.   |        |   |                         | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                              |                 | 4/28/68                                 |                          |  |
|   |         |  |        |   |                         | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                                 |                 | ADDRESS (Street, city, town, or county) |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY  |                         | 23d. LOCATION (City or Town) (County) (State)                                    |                 |   |                          |  |
| Burial  |         | 5-1-1968   |        | Gardens of Faith Cemetery   |                         | Baltimore, Co. Md.   |                 |   |                          |  |
| 24. FUNERAL DIRECTOR  |         |  |        | ADDRESS   |                         | 25a. REC'D BY REGISTRAR  |                 | 25b. REGISTRAR'S SIGNATURE              |                          |  |
| Lassahn Funeral Home  |         |  |        | 7401 Delair Road 21236  |                         | MAY 2 1968   |                 | Charles Judge                           |                          |  |

4032

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

|   |                              |   |                                    |   |                                     |  |          |
|---|------------------------------|---|------------------------------------|---|-------------------------------------|--|----------|
| 05203   |                              | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |                                    |   |                                     | 05207                                    |          |
| 1. DECEASED-NAME<br>(Type or print)   |                              | First   | Middle                             | Last  | 2a. DATE OF DEATH<br>Month Day Year |  | 2b. HOUR |
| EARL  |                              | JOSEPH  | COCHRAN                            | APRIL   | 10                                  | 1968                                     | 2:10 M   |
| 3. SEX  | 4. RACE                      | 5. DATE OF BIRTH  |                                    | 6. AGE (In years last birthday)   |                                     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |          |
| MALE  | WHITE                        | JUNE 29, 1929   |                                    | 38 YRS.   |                                     |  |          |
| 7a. BIRTHPLACE (State or foreign country)   | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |                                     | Md.                                      |          |
| PENNSYLVANIA  | U.S.A.                       |   |                                    | BALTIMORE   |                                     |  |          |
| 10. CITY OR TOWN OF DEATH   |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)         |                                     | 12b. KIND OF BUSINESS OR INDUSTRY        |          |
| TOWSON  |                              | ST. JOSEPH HOSPITAL   |                                    | SOCIAL SECURITY   |                                     |  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |                              | 13b. COUNTY   | 13c. CITY OR TOWN                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER              |  |          |
| MARYLAND  |                              |   | BALTIMORE                          |   | 5513 SEWARD AVE. #21206             |  |          |
| 14. FATHER'S NAME   |                              | First   | Middle                             | Last  | 15. MOTHER'S MAIDEN NAME            |  |          |
| Earl  |                              | L.  | Cochran                            | Rose  | Schlewinski                         |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |                              | 16b. SOCIAL SECURITY NO.  |                                    | 17. INFORMANT   |                                     | Address                                  |          |
| Yes   |                              | 215-24-1240   |                                    | Mrs. Marlene Cochran  |                                     | (Same)                                   |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>5932<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Uremia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Chronic renal insufficiency</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                              |   |                                    |   |                                     |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                              |   |                                    |   |                                     |  |          |
| 19a. DATE OF OPERATION  |                              |   |                                    |   |                                     |  |          |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                              |   |                                    |   |                                     |  |          |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                              |   |                                    |   |                                     |  |          |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                              |   |                                    |   |                                     |  |          |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                 |                                     |  |          |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                                    |                                     |  |          |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>APRIL 9</u> , 19 <u>68</u> , to <u>APRIL 10</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>APRIL 10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                              |   |                                    |   |                                     |  |          |
| 22b. SIGNATURE  |                              | 22c. DATE SIGNED  |                                    |   |                                     |  |          |
| Ines Cilliani, M.D.   |                              | April 10, 1968  |                                    |   |                                     |  |          |
| 22d. PHYSICIAN'S NAME (Type)  |                              | 22e. ADDRESS  |                                    |   |                                     |  |          |
|   |                              | 7620 York Rd., Towson, Md. 21204  |                                    |   |                                     |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                              | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State)   |                                     |  |          |
| Burial  |                              | 4/15/68.  | Balto. National Cem.               | Baltimore, Md.  |                                     |  |          |
| 24. FUNERAL DIRECTOR  |                              | ADDRESS   |                                    | 25a. REC'D BY REGISTRAR   |                                     | 25b. REGISTRAR'S SIGNATURE               |          |
| Leonard J. Ruck, Inc.   |                              | Balto. Md. 21214  |                                    | DATE 11 1968  |                                     | Charles Judge                            |          |

80320

UNITED STATES OF AMERICA

1952

*[Faint, mostly illegible text, possibly a letter or report, spanning the main body of the page.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>SYDNE  |  |  | Middle<br>V.  |  |  | Last<br>COCHRANE  |  |  | 2a. DATE OF DEATH<br>APRIL Month 13 Day 1968 Year           |  |  | 2b. HOUR<br>M    |  |  |
| 3. SEX<br>F   |  |  | 4. RACE<br>W  |  |  | 5. DATE OF BIRTH<br>AUG. 29, 1888   |  |  | 6. AGE (in years<br>last birthday)<br>79 YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                   |  |  | IF UNDER 24 HRS. |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>MD.   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>BALTIMORE Md.   |  |  |   |  |  |                  |  |  |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>406 OAK FOREST AVE |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>HOUSEKEEPER   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>NONE  |  |  |   |  |  |                  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>MD.   |  |  | 13b. COUNTY<br>BALTO  |  |  | 13c. CITY OR TOWN<br>CATONSVILLE  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>406 OAK FOREST AVE.               |  |  |                  |  |  |
| 14. FATHER'S NAME<br>First<br>CHARLES E.  |  |  | Middle<br>COCHRANE  |  |  | Last<br>ANNABELLE   |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>ANNABELLE  |  |  | Middle<br>HALL  |  |  | Last             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.<br>—   |  |  | 17. INFORMANT<br>William H. Thompson  |  |  |   |  |  | Address<br>406 Oak Forest Ave.                              |  |  |                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Neermarkage</u><br>4319 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Fractured Hip -</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Neermarkage - infection</u><br>b. m. h. s. |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>2 months |  |  |                  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>331X  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |   |  |  |                  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |   |  |  |                  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                       |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |   |  |  |                  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>APR 11, 1968</u> to <u>APR 12, 1968</u> , that (I) (we) last<br>saw the deceased alive on <u>APR 11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |
| 22b. SIGNATURE<br>Frederic J. Beitel  |  |  | DEGREE<br>ATTENDING<br>PHYS.  |  |  | MED.<br>DIRECTOR <input checked="" type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>  |  |  | 22c. DATE SIGNED<br>4-24-68   |  |  |   |  |  |                  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>FREDERICK V. BEITLER   |  |  | 22e. ADDRESS<br>1014 Towson Ave - (Jesse M. W.)   |  |  |   |  |  |   |  |  |   |  |  |                  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  |  | 23b. DATE<br>4-25-1968  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Grand Ridge Cem.  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Catonville Ind.                                |  |  |   |  |  |                  |  |  |
| 24. FUNERAL DIRECTOR<br>Torley C. Crampton  |  |  | ADDRESS<br>27 N. Catonsville, Ind.  |  |  | 25a. BY REGISTRAR<br>DATE<br>APR 26 1968  |  |  | 25b. REGISTRAR'S SIGNATURE<br>William H. Thompson   |  |  |   |  |  |                  |  |  |

2

11

10

10

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |   |   |  |  |                                   |
|---|--|--|--|--|---|---|--|--|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |   |  |  |                                   |
| CERTIFICATE OF DEATH  |  |  |  |  |   |   |  |  |                                   |
| 05205   |  |  |  |  |   |   |  |  |                                   |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |  |   | 2a. DATE OF DEATH   |  |  | 2b. HOUR                          |
| SHIRLEY   |  |  | MAE  |  |   | COCKERHAM   |  |  | 4:45 P M                          |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |   |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS       |
| FEMALE  |  | CAUCASIAN  |  | 2-10-66  |   |   | 2 YRS.   |  | HOURS MIN.                        |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |  |                                   |
| MARYLAND  |  | USA  |  |  |   | BALTIMORE Md.   |  |  |                                   |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE   |  |  | Greater Baltimore Medical Center   |  |   | None  |  |  | U. S. A.                          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER            |
| MARYLAND  |  |  | BALTIMORE  |  | DUNDALK   |   |  |  | 1245 Willow Road.                 |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |   |   |  |  |                                   |
| ARLEN B COCKERHAM   |  |  | SHIRLEY JEFFERIES  |  |   |   |  |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT (Father) Address  |   |  |  |                                   |
| NO  |  |  | None   |  | Mr. Arlen B. Cockerham, 1245 Willow Rd. Dundalk, Md.                              |   |  |  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |   |   |  |  |                                   |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |   |   |  |  |                                   |
| IMMEDIATE CAUSE (a) <u>Splenic abdominal hemorrhage from the liver</u>  |  |  |  |  |   |   |  |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |   |   |  |  |                                   |
| (b) <u>Massive hepatomegaly secondary to tumor</u>  |  |  |  |  |   |   |  |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |   |   |  |  |                                   |
| (c) <u>Hyperkalemia + cardiac arrest</u>  |  |  |  |  |   |   |  |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |   |   |  |  |                                   |
| 230x  |  |  |  |  |   |   |  |  |                                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |  |                                   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No.  |   | City or Town   |  | County State                      |
| 22a. I certify that (this hospital) attended the deceased from 4:23, 1968, to 7:25, 1968, that (I) (we) last saw the deceased alive on 4:25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |   |  |  |                                   |
| 22b. SIGNATURE <u>Jeffrey J. Mitchell</u>   |  |  |  |  | 22c. DATE SIGNED  |   | 4/25/68  |  |                                   |
| 22d. PHYSICIAN'S NAME (Type) <u>Mitchell</u>  |  |  |  |  | 22e. ADDRESS  |   | Greater Balto. Med. Center, Towson, Md.  |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |  |  |                                   |
| Burial  |  | 4/29/68  |  | Oak Lawn Cemetery  |   | Baltimore, Md.  |  |  |                                   |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE  |   | 25b. REGISTRAR'S SIGNATURE   |  |                                   |
| John J. Duda, 7922 Wise Ave. Dundalk, Md.   |  |  |  |  | APR 30 1968   |   | <u>Charles Judge</u>   |  |                                   |

00300

OFFICE OF THE ATTORNEY GENERAL

00300

OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

IN SENATE

January 1, 1900

REPORT OF THE

COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR 1899

ALBANY:

THE UNIVERSITY OF THE STATE OF NEW YORK

1900

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1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05206

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05210

|  |         |  |                  |   |                                     |  |                                |   |                               |
|--|---------|--|------------------|---|-------------------------------------|--|--------------------------------|---|-------------------------------|
| 1. DECEASED-NAME<br>(Type or print)  |         | First  | Middle           | Last  | 2a. DATE OF DEATH<br>Month Day Year |  |                                | 2b. HOUR  |                               |
| Ethel  |         | Bertram  | Cogswell         |   | 4                                   | 28   | 68                             | 12:10 PM  |                               |
| 3. SEX   | 4. RACE |  | 5. DATE OF BIRTH |   | 6. AGE (In years last birthday)     |  | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS<br>HOURS MIN. |
| Female   | White   |  | 12-24-90 1880    |   | 37 YRS.                             |  |                                |   |                               |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. COUNTY OF DEATH   |                                |   |                               |
| Maryland   |         | United States  |                  |   |                                     | Baltimore County Md.   |                                |   |                               |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                     | 12b. KIND OF BUSINESS OR INDUSTRY  |                                |   |                               |
| Lutherville  |         | College Manor Nursing Home   |                  | Housewife   |                                     |  |                                |   |                               |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         | 13b. COUNTY  |                  | 13c. CITY OR TOWN   |                                     | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                | 13e. STREET AND NUMBER  |                               |
| Maryland   |         | Baltimore  |                  | Pikesville  |                                     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                | Old Court Road  |                               |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)  |                                     | 16b. SOCIAL SECURITY NO.   |                                | 17. INFORMANT Address   |                               |
| William T. Cox   |         | Francis Rebecca Ensor  |                  | No  |                                     | 220-44-3983  |                                | Mr. William K. Cogswell, Golf Course Rd. Garrison, Md.                                      |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>C.V.A.</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis (cardiac)</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u><br>Approximate interval between onset and death: 10 days, 6 months, 5 years |         |  |                  |   |                                     |  |                                |   |                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>331X</u>  |         |  |                  |   |                                     |  |                                |   |                               |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                |   |                               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                     |  |                                |   |                               |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  | 21f. LOCATION Street or R.F.D. No.  |                                     | City or Town   |                                | County State  |                               |
|  |         |  |                  |   |                                     |  |                                |   |                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 27, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |         |  |                  |   |                                     |  |                                |   |                               |
| 22b. SIGNATURE   |         | 22c. DATE SIGNED   |                  | 22d. PHYSICIAN'S NAME (Type)  |                                     | 22e. ADDRESS   |                                | 22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                               |
| Palmer F.C. Williams   |         | May 1, 68  |                  | Palmer F.C. Williams  |                                     | Lincoln Rd. Owings Mills Md.   |                                |   |                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY  |                                     | 23d. LOCATION (City or Town) (County) (State)  |                                |   |                               |
| Burial   |         | May 1, 1968  |                  | Druid Ridge Cemetery  |                                     | Pikesville Baltimore, Md.  |                                |   |                               |
| 24. FUNERAL DIRECTOR   |         | 25a. RECEIVED BY REGISTRAR   |                  | 25b. REGISTRAR'S SIGNATURE  |                                     | 25c. DATE  |                                |   |                               |
| Frank H. Newell  |         | MAY 7 1968   |                  | John J. Judge   |                                     |  |                                |   |                               |

1985



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |   |   |  |  |  |
|---|--|--|--|--|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |   |   |  |  |  |
| 05207   |  |  |  |  |   |   |  |  |  |
| 05211   |  |  |  |  |   |   |  |  |  |
| 1. DECEASED-NAME (Type or print)  |  |  | First Middle Last  |  |   | 2a. DATE OF DEATH   |  | 2b. HOUR                                     |  |
| THOMAS MARTIN CONNELLY  |  |  |  |  |   | APRIL Month 3 Day 1968 Year   |  | 2:20 a. M                                    |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years lost birthday)   |  | IF UNDER 1 YEAR                              |  |
| MALE  |  | CAUC   |  | 10-4-85  |   | 82 YRS.   |  | MONTHS DAYS HOURS MIN                        |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |  |  |
| PITTSBURG   |  | U.S.   |  |  |   | Baltimore Md  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Catonsville   |  |  | SPRING GROVE   |  |   | TRUCKING BUSINESS   |  | SAME   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)   |  |  | 13b. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET AND NUMBER   |  |  |
| MD  |  |  | PRINCE GEORGE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 3208 TOLEDO PLACE  |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |  |  |  |
| First Middle Last   |  |  | First Middle Last  |  |   |   |  |  |  |
| MARTIN GEORGE RICHARD   |  |  | MARY UNKNOWN ALICE DANIELS   |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |   | Address  |  |  |
| No  |  |  | 028-20-7531  |  | JOSEPH SPISICK  |   | 3208 TOLEDO PLACE  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |   |   |  | 3 HOURS                                      |  |
| IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION   |  |  |  |  |   |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |   |   |  |  |  |
| (b) ARTERIOSCLEROTIC HEART DISEASE  |  |  |  |  |   |   |  | YEARS  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |   |   |  |  |  |
| (c) SENILITY  |  |  |  |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |   |   |  |  |  |
| 4201  |  |  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
|   |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |   |   |  |  |  |
|   |  | HOUR A.M. Month Day Year P.M. 19   |  |  |   |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |  |  |
|   |  |  |  |  |   |   |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from July 13, 19 67, to April 3, 19 68, that (X) (we) last saw the deceased alive on April 3, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |   |  |  |  |
| 22b. SIGNATURE Narciso Aristigueta MD   |  |  |  |  |   | DEGREE  |  | 22c. DATE SIGNED                             |  |
|   |  |  |  |  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 4-3-68                                       |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |   | 22e. ADDRESS  |  |  |  |
| NARCISO ARISTIGUETA   |  |  |  |  |   | Baltimore, Maryland 21228   |  |  |  |
|   |  |  |  |  |   | SPRING GROVE STATE HOSPITAL   |  |  |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |
| Burial  |  | April 6, 1968  |  | Mount Olivet Cemetery  |   | Washington D. C   |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |   | ADDRESS   |  | 25. REC'D BY REGISTRAR                       |  |
| Takoma Funeral Home, J. Arthur Walker   |  |  |  |  |   | 27 Carroll (D. N. W.)   |  | 26. REGISTRAR'S SIGNATURE                    |  |
|   |  |  |  |  |   | DATE APR 5 - 1968   |  | Charles Judge                                |  |

1951

OFFICE OF DEATH

00501



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 1/68  
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |  |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  |
| 1. DECEASED NAME (Type or print) First Middle Last<br><b>MARY ANNE COUGHLIN</b>  |  |   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>APRIL 7 1968</b> |   |  | 2b. HOUR<br><b>9 55PM</b>  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br><b>1-15-87</b>   |  | 6. AGE (In years last birthday)<br><b>81</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>IRELAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A</b>  |  | 8. MARRIED <input type="checkbox"/> <del>WIDOWED</del> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> |  | 9. COUNTY OF DEATH<br><b>Baltimore County, Md.</b>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mount Wilson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Wilson State Hosp.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>TEACHER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>VISITATION SISTER</b>                                   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>—</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>5712 ROLAND AVE</b>                 |  |
| 14. FATHER'S NAME First Middle Last<br><b>JOHN CROTTY</b>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>MARGARET DAVINE</b>  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-541-2916</b>   |  | 17. INFORMANT Address<br><b>Records, Mt. Wilson State Hospital</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>FAR ADVANCED PULM T.B. ACTIVE</b><br><b>011.2</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>2021</b> |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-25</b> , 1968, to <b>4-7-</b> , 1968, that (I) (we) last saw the deceased alive on <b>4-7-</b> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>W Newcomer</b>  |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                    |  | 22c. DATE SIGNED  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William Newcomer, M.D.</b>  |  | 22e. ADDRESS<br><b>Mount Wilson, Maryland</b>   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>APRIL 9/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CATHEDRAL</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MD.</b>                          |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>H.W. MEARS &amp; SON 805 N. CALVERT ST.</b>   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 11 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>f Charles Judge</b>  |  |  |  |

2030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| Item 22 Film 400 5-3-68 MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |                                      |  |                    |  |
|---|--|--|--|--|--|--|--|--------------------------------------|--|--------------------|--|
| Item 13 Film G400 5/2/68 <b>CERTIFICATE OF DEATH</b> 05213  |  |  |  |  |  |  |  |                                      |  |                    |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle   |  | Last   |  | 2a. DATE OF DEATH                    |  | 2b. HOUR           |  |
| Miss Mary   |  | R  |  | R  |  | Creaghan   |  | 4 Month 13 Day 68 <sup>th</sup> Year |  | 1:45 P.M.          |  |
| 3. SEX  |  | A. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR                      |  | IF UNDER 24 HRS.   |  |
| Female  |  | White  |  | Sept 14 1892   |  | 75 16 YRS.   |  | MONTHS DAYS HOURS MIN.               |  |                    |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                                      |  |                    |  |
| Unknown   |  | America  |  |  |  | Baltimore  |  | Md.                                  |  |                    |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                      |  |                    |  |
| Baltimore   |  | Summit Nursing Home  |  | AT HOME  |  |  |  |                                      |  |                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER               |  | 13f. W. Lombard ST |  |
| Md.   |  | Baltimore  |  | Baltimore  |  |  |  | 918 Southwick Ave                    |  |                    |  |
| 14. FATHER'S NAME   |  | First  |  | Middle   |  | Last   |  | 15. MOTHER'S MAIDEN NAME             |  | First Middle Last  |  |
| Ostrick   |  | J.   |  |  |  | Creaghan   |  | Margaret                             |  | O'Brien            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address                              |  |                    |  |
|   |  |  |  |  |  | (Spouse for record) Catherine J. Stump, R.N.   |  |                                      |  |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 395.9 PULMONARY EMBOLUS<br>DUE TO, OR AS A CONSEQUENCE OF 2 FRACTURED H.I.P., left femur at hospital<br>(b) AORTIC STENOSIS<br>DUE TO, OR AS A CONSEQUENCE OF 1 A.S.C.D.<br>(c) 5 Multiple decubiti ulcers<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>395.9 2 FRACTURED H.I.P., left femur at hospital 395.9 2 FRACTURED H.I.P., left femur at hospital 395.9 2 FRACTURED H.I.P., left femur at hospital |  |  |  |  |  |  |  |                                      |  |                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>421.1  |  |  |  |  |  |  |  |                                      |  |                    |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                                      |  |                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |                                      |  |                    |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |                                      |  |                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 7 1968, to April 13, 1968, that (I) (we) last saw the deceased alive on April 12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Natural causes  |  |  |  |  |  |  |  |                                      |  |                    |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |                                      |  |                    |  |
| E. KASATI'S, M.D.   |  | 4/13/68  |  | E. KASATI'S, M.D.  |  | 1801 FREDERICK RD; BALTIMORE MD  |  |                                      |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |                                      |  |                    |  |
| BURIAL  |  | 4/16/68  |  | NEW CATHEDRAL  |  | BALTIMORE MD.  |  |                                      |  |                    |  |
| 24. FUNERAL DIRECTOR  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  | 25c. DATE  |  |                                      |  |                    |  |
| H.W. MEARS & SON 805 N. CALVERT ST  |  | APR 17 1968  |  | Charles Judge  |  |  |  |                                      |  |                    |  |



*[Faint, mostly illegible handwritten text and markings across the page, possibly bleed-through from the reverse side.]*



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

05210

05214

|  |  |   |  |  |  |  |   |
|--|--|---|--|--|--|--|---|
| 1. DECEASED-NAME<br>(Type or print) <i>William Stewart</i>   |  | First <i>William</i> Middle <i>Stewart</i> Last <i>Crichton</i>   |  | 2a. DATE OF DEATH<br>Month <i>April</i> Day <i>28</i> Year <i>1968</i>   |  | 2b. HOUR<br><i>11:00 PM</i>  |   |
| 3. SEX<br><i>male</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br><i>May 17 1892</i>   |  | 6. AGE (In years last birthday)<br><i>76</i> YRS.  |   |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Scotland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>US</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.   |   |
| 10. CITY OR TOWN OF DEATH<br><i>Towson</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Dulany Towson Nurse Home</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Landscaping</i>                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>  |  | 13b. COUNTY <i>Baltimore</i>  |  | 13c. CITY OR TOWN<br><i>Towson</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |   |
| 13e. STREET AND NUMBER<br><i>1007 KATY Lane</i>  |  | 14. FATHER'S NAME<br>First <i>Crichton</i> Middle <i>JoAnn</i> Last <i>Crichton</i>                             |  | 15. MOTHER'S MAIDEN NAME<br>First <i>JoAnn</i> Middle <i>Crichton</i> Last <i>Crichton</i>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, <i>NO</i> (If yes give war or dates of service) |   |
| 16b. SOCIAL SECURITY NO.<br><i>371-05-3485</i>   |  | 17. INFORMANT<br><i>Mrs. Richard F. Meehan</i>  |  | Address<br><i>1007 Katy Lane 21204</i>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br><i>342X</i> IMMEDIATE CAUSE (a) <i>Hypostatic pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Parkinson's Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i> |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 week</i><br><i>2 yrs</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>350X</i>  |  |   |  |  |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                 |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                    |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>January 1966</i> to <i>April 1968</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>April 25 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) (did not) view the body after death.                           |  |   |  |  |  |  |   |
| 22b. SIGNATURE<br><i>A. Allan Sier, MD</i>   |  |   |  | DEGREE<br><i>MD</i>  |  | 22c. DATE SIGNED<br><i>4/28/68</i>   |   |
| 22d. PHYSICIAN'S NAME (Type)   |  |   |  | 22e. ADDRESS   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Cremation</i>  |  | 23b. DATE<br><i>5/1/68</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Green Mount Crematory</i>   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Maryland</i>                          |   |
| 24. FUNERAL DIRECTOR<br><i>Wm. Cook-Brooks Towson 1050 York Rd. 21204</i>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <i>MAY 3 1968</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02514

RECEIVED

02530

W.A. 1935

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05211

MD. STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05215

|   |  |  |  |   |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Sadie</b>   |  | First<br><b>U.</b>   |  | Middle<br><b>CROISSETTE</b>   |  | Last  |  | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>4</b> Year <b>1968</b> |  | 2b. HOUR<br><b>7:45AM</b>                    |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>June 11, 1892</b>  |  | 6. AGE (In years lost birthday)<br><b>75</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____                            |  | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore,</b> Md.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. JOSEPH HOSPITAL</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CANDY</b>   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Balt.</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>3009 Linwood Ave.</b>                    |  |  |  |
| 14. FATHER'S NAME First<br><b>ISSAC</b>   |  | Middle<br><b>CUDDY</b>   |  | Last  |  | 15. MOTHER'S MAIDEN NAME First<br><b>MATILDA</b>  |  | Middle<br><b>BISCOE</b>   |  | Last   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No.</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>—</b>   |  | 17. INFORMANT<br><b>Mr. Stanley Griffith</b>  |  | Address<br><b>309 Linwood Cve.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple myeloma</b><br><b>203X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>203X</b>   |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. _____ Month _____ Day _____ Year <b>19</b><br>P.M. _____                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____  |  |   |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>3/30/</b> , 19 <b>68</b> , to <b>4/4/</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/4/</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Vichian Phupakdi</b>   |  | DEGREE   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>April 4, 1968</b>  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Vichian Phupakdi, M.D.</b>   |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>  |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4-6-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WOODLAWN Cem.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO., MD.</b>                             |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Stanley Miller</b>   |  | ADDRESS<br><b>2334 JEFFERSON ST.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>APR 8 - 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jones</b>  |  |   |  |  |  |

MEDICAL CERTIFICATION

1952

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

| 05212   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 05216  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Michael Jenkins Cromwell, Sr.   |  |  |  |  |  |  |  |  |  | April 30, 1968   |  |  |  |  |  |  |  |  |  | 8:55 A M   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 3. SEX M  |  |  |  |  |  |  |  |  |  | 4. RACE W  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH 10/25/1901  |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday) 66 YRS.  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS           |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) Maryland  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? U. S. A.  |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH Baltimore Md.   |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH Lutherville   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box 504 RD#1, Lutherville                                 |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) President P.J. McEvoy & Sons                                     |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY Importers  |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.   |  |  |  |  |  |  |  |  |  | 13b. COUNTY Baltimore  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN Riderwood  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER Box 504- RD #1 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last William Kennedy Cromwell  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last Sally Franklin  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. WWII 212-09-5663  |  |  |  |  |  |  |  |  |  | 17. INFORMANT Mrs. Maria McEvoy Cromwell   |  |  |  |  |  |  |  |  |  | Address (Same)   |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 185X Carcinoma of Prostate<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 177X  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 1962, to April 30, 1968, that (I) (we) last saw the deceased alive on April 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE William F. Fritz MD  |  |  |  |  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED 4/30/68   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) William F. Fritz M.D.  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS 2 W. University Plwy.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  |  |  |  |  |  |  |  |  | 23b. DATE 5/2/68   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) Baltimore Md.                                  |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.  |  |  |  |  |  |  |  |  |  | ADDRESS 4905 York Rd. Balto. 12, Md.   |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR MAY 3 1968   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE [Signature]   |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |

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# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |   |   |  |  |  |
|--|--|--|---|--|--|---|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |   |  |  |   |   |  |  |  |
| 1. DECEASED-NAME (Type or Print) <b>James Francis Dalton</b>   |  |  |   |  | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year <b>APR 29 1968</b> |   |   | 2b. HOUR <b>6:31 PM</b>  |  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>   |   | 5. DATE OF BIRTH <b>3/5/1901</b>   |  | 6. AGE (In years last birthday) <b>67</b> YRS.  |   | 7c. DATE PRONOUNCED DEAD Month <b>4</b> Day <b>29</b> Year <b>1968</b>           |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore</b> Md.   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>White Hall</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>West Liberty Road</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  |  | 13b. COUNTY <b>Baltimore</b>  |  |  | 13c. CITY OR TOWN <b>White Hall</b>   |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER <b>RD # 2, Box 104</b>  |  |  |   |  |  |   |   |  |  |  |
| 14. FATHER'S NAME First <b>John T.</b> Middle <b>Dalton</b> Last <b>Dalton</b>   |  |  |   |  | 15. MOTHER'S MAIDEN NAME First <b>Viola</b> Middle <b>Shawn</b> Last <b>Dalton</b>                       |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  |  | 16b. SOCIAL SECURITY NO. <b>219-36-0763</b>   |  |  | 16c. MARRIAGE STATUS <b>Mrs.</b>  |   |  | ADDRESS <b>RD #2 Box 104 White Hall, Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |   |  |  |   |   | 21161 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                               |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>4201</b>   |  |  |   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  | 21b. TIME OF INJURY Month, Day, Year <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                          |   |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |   |  |  |   |   |  |  |  |
| ACTUAL SIGNATURE <b>A.M. France</b>  |  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |   |  |  |  |
| EXAMINER'S NAME (Type) <b>A.M. FRANCE</b>  |  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |   |  |  |  |
|  |  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |   |  |  |  |
|  |  |  |   |  | ADDRESS (Street, city, town, or county) <b>DARTON, Md.</b>   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |  | 23b. DATE <b>5/2/1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>  |   |   | 23d. LOCATION (City or Town) (County) (State) <b>Hyde, Baltimore, Maryland</b>   |  |  |
| 24. FUNERAL DIRECTOR <b>Charles E. Kurtz Jarrettsville, Md.</b>  |  |  |   |  | 25a. REC'D BY REGISTRAR <b>MAY 01 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b> |  |  |  |

05211

05211

CONCERNING

4/2/48  
BOSTON, MA

AMERICA

MAY 11 1948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (4)  
30M REV. 1-66

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |                           |   |  |   |  |  |   |  |  |                         |  |  |
|--|--|---|---------------------------|---|--|---|--|--|---|--|--|-------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |                           |   |  |   |  |  |   |  |  |                         |  |  |
| CERTIFICATE OF DEATH   |  |   |                           |   |  |   |  |  |   |  |  |                         |  |  |
| 05218  |  |   |                           |   |  |   |  |  |   |  |  |                         |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First<br><b>RALPH</b>     |   |  | Middle<br><b>EARL</b>   |  |  | Last<br><b>DAWSON</b>                           |  |  |                         |  |  |
| 2a. DATE OF DEATH  |  |   | Month<br><b>APRIL</b>     |   |  | Day<br><b>1</b>   |  |  | Year<br><b>1968</b>                             |  |  |                         |  |  |
| 2b. HOUR   |  |   | <b>2:30PM</b>             |   |  |   |  |  |   |  |  |                         |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>NEGRO</b>   |                           | 5. DATE OF BIRTH<br><b>2/3/32</b>   |  | 6. AGE (In years last birthday)<br><b>36</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br><b></b> DAYS<br><b></b>                               |   | IF UNDER 24 HRS.<br>HOURS<br><b></b> MIN.<br><b></b> |  |                         |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>NORTH CAROLINA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                           | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY,</b> Md.  |  |  |   |  |  |                         |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET. ADM. HOSPITAL</b> |                           | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>LABORER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SHIP BUILDING</b>                                       |  |  |   |  |  |                         |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |                           | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>1103 N. Fulton Avenue</b>                             |   |  |  |                         |  |  |
| 14. FATHER'S NAME<br>First<br><b>FRED</b>  |  |   | Middle<br><b>CRAWFORD</b> |   |  | Last<br><b>ADA</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br><b>ADA</b> |  |  | Middle<br><b>DAWSON</b> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/>  |  | 16b. SOCIAL SECURITY NO.<br><b>PL 28 239 42 02 72</b>   |                           | 17. INFORMANT<br>Address<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>   |  |   |  |  |   |  |  |                         |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>BRONCHOGENIC CARCINOMA LEFT LUNG WITH METASTASIS TO</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>LYMPH NODES, LUNG, KIDNEY AND BRAIN</b><br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>RECENT</b> |  |   |                           |   |  |   |  |  |   |  |  |                         |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>1621</b>  |  |   |                           |   |  |   |  |  |   |  |  |                         |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                           |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> |   |  |  |                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |                           | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |   |  |  |                         |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |                           | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |   |  |  |                         |  |  |
| 22a. I certify that <b>(b)</b> (this hospital) attended the deceased from <b>2/24/68</b> , 19____, to <b>4/1/68</b> , 19____, that <b>(4)</b> (we) last saw the deceased alive on <b>4/1/68</b> , 19____, and that in <b>(4)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(b)</b> (we) (did) (did not) view the body after death.  |  |   |                           |   |  |   |  |  |   |  |  |                         |  |  |
| 22b. SIGNATURE<br><b>Peter D. Juvan</b>  |  |   |                           |   |  |   |  |  |   | 22c. DATE SIGNED<br><b>4/2/68</b>                    |  |                         |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>PETER D. JUVAN, M. D.</b>   |  |   |                           |   |  |   |  |  |   | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>     |  |                         |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4-5-68</b>  |                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO NATIONAL CEMETERY</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE MARYLAND</b>                      |  |  |   |  |  |                         |  |  |
| 24. FUNERAL DIRECTOR<br><b>MORTON &amp; DYETT FUNERAL HOME</b><br><b>1701 LAURENS, BALTIMORE, MARYLAND</b>   |  |   |                           | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 4 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                 |   |  |  |                         |  |  |

*[The page contains faint, mirrored text from the reverse side, which appears as bleed-through. The text is largely illegible due to its orientation and fading.]*

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 13e File # 399 4/8/68  
05215  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05219

|  |                         |  |  |   |   |  |  |  |
|--|-------------------------|--|--|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)<br>First Middle Last<br><b>CALVIN Martin DEAN</b>  |                         |  | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br><b>April 4 1968</b>     |   |   | 2b. HOUR<br>M<br><b>M</b>  |  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>8-14-95</b>   | 6. AGE (In years lost birthday)<br><b>72</b> YRS.                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>72</b>   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>72</b> | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>April 4 1968</b>                    |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           |   | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Spring Grove Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>1031 Maiden Choice Lane</b><br><b>Spring Grove State Hospital</b> |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Martin Dean</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Rebecca Dean</b> |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>WWI</b>  |                         | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>212-10-1161</b>                      |  | 17. INFORMANT<br><b>Mrs. Gladys A. Dean</b>   |   | ADDRESS<br><b>21229 1031 Maiden Choice Lane</b>                                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>571.9</b> IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a):<br>stating the underlying cause lost. } (b) <b>Cirrhosis of liver</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)  |                         |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>581.0</b>  |                         |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                 |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |  |   |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Charles S. Springate</b>  |                         | EXAMINER'S NAME (Type)<br><b>Charles S. Springate, M.D.</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |   | 22b. DATE SIGNED<br><b>April 4, 1968</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 23b. DATE<br><b>4/8/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>                |  |  |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>  |                         |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 8 - 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                   |  |  |

01930

OFFICE OF THE ATTORNEY GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05216

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05220

|  |  |  |  |   |  |   |   |  |                                |  |                                |  |
|--|--|--|--|---|--|---|---|--|--------------------------------|--|--------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br><b>EMMA</b>   |  | Middle<br><b>M.</b>   |  | Last<br><b>DEIGERT</b>  |   | 2a. DATE OF DEATH<br><b>APRIL</b> Month <b>4</b> , Day <b>1968</b> Year  |                                |  | 2b. HOUR<br><b>5:45</b> M      |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>DECEMBER 8, 1882</b>   |  |   | 6. AGE (In years last birthday)<br><b>85</b> YRS.                         |  | IF UNDER 1 YEAR<br>MONTHS DAYS |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE,</b> Md.   |   |  |                                |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. JOSEPH HOSPITAL</b>     |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)<br><b>HOMEMAKER</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                                |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>8019 BELAIR ROAD #21236</b>   |                                |  |                                |  |
| 14. FATHER'S NAME First Middle Last<br><b>Joseph Tremper</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Anna Kaulp</b>   |  |   |   |  |                                |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-21-7740</b>   |  | 17. INFORMANT Address<br><b>Mr Joseph D. Deigert Box 57 Fork, Md. 21051</b>   |  |   |   |  |                                |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Extensive diverticulosis</b><br><b>5621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Abscess sigmoid</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Peritonitis</b> (d) <b>Fecal fistula</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |   |  |                                |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>5721</b>   |  |  |  |   |  |   |   |  |                                |  |                                |  |
| 19a. DATE OF OPERATION<br><b>2/28/68</b><br><b>3/20/68</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Intestinal obstruction, Sigmoid perforation postco.</b> |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                                |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |                                |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |                                |  |                                |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>FEBRUARY 26, 1968</b> , to <b>APRIL 4, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>APRIL 4, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |   |  |                                |  |                                |  |
| 22b. SIGNATURE<br><b>Anibal Escobar, M.D.</b>  |  |  |  |   |  |   |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                                | 22c. DATE SIGNED<br><b>April 4, 1968</b> |                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Anibal Escobar</b>  |  |  |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>   |  |   |   |  |                                |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4-6-1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Cemetery</b>   |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Co. Md.</b> |  |                                |  |                                |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Lessard Funeral Home 7401 Belair Road</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>APR 10 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |  |                                |  |                                |  |

08316

08316

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings for future research. The final part of the report is a conclusion and a list of references.

2. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings for future research. The final part of the report is a conclusion and a list of references.

3. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings for future research. The final part of the report is a conclusion and a list of references.

4. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings for future research. The final part of the report is a conclusion and a list of references.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

05221

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) <b>ANNA</b>  |  | First Middle Last <b>M. DEMARCO</b>   |  | 2a. DATE OF DEATH <b>APR</b> Month <b>7</b> Day <b>68</b> Year   |  | 2b. HOUR <b>7:30AM</b>   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH <b>Feb. 27, 1882</b>  |  | 6. AGE (In years last birthday) <b>86</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Indiana</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>211 Dumbarton Rd.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Towson</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER <b>211 Dumbarton Rd.</b>   |  | 14. FATHER'S NAME First <b>Hugh</b> Middle <b>J.</b> Last <b>Fitzpatrick</b>                          |  | 15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Mullin</b> Last   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO. <b>215-30-0940</b>   |  | 17. INFORMANT Address <b>Mrs. Amelia E. Donohue 211 Dumbarton Rd.</b>  |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4109 ACUTE MYOCARDIAL INFARCTION</b> MIN.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTEIOSCLEROTIC CARDIOVASCULAR DISEASE</b> YEARS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JUL</b> , 19 <b>65</b> , to <b>APR</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>6 APR</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE <b>Salvatore R. Donohue MD</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |   |  | 22c. DATE SIGNED <b>7 APR. 68</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>SALVATORE R. DONOHUE MD</b>   |  |   |  | 22e. ADDRESS <b>7418 STANMORE CT, BALTO. MD.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  | 23b. DATE <b>4/10/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>                          |  |
| 24. FUNERAL DIRECTOR <b>Leonard J. Ruck, inc. 5305 Harford Rd.</b> ADDRESS  |  |   |  | 25a. REC'D BY REGISTRAR <b>APR 9 1968</b> DATE   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |                          |   |  |  |  |                        |  |
|--|--|--|--------------------------|---|--|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                          |   |  |  |  |                        |  |
| CERTIFICATE OF DEATH   |  |  |                          |   |  |  |  |                        |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last        |   |  | 2a. DATE OF DEATH  |  | 2b. HOUR               |  |
| John Irvin <del>XXXXX</del> Denbow, Sr.  |  |  |                          |   |  | Month 4 Day 21 Year 68   |  | 5:15PM                 |  |
| 3. SEX   |  | 4. RACE  |                          | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)                                      |  | IF UNDER 1 YEAR        |  |
| Male   |  | Caucasian  |                          | 10/29/11  |  | 56 YRS.  |  | MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                        |  |
| Maryland   |  | U.S.A.   |                          |   |  | Baltimore  |  | Md.                    |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |                        |  |
| Baltimore  |  | Greater Balto. Med. Center   |                          | Self-Employed   |  | Tavern   |  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET AND NUMBER |  |
| Maryland   |  |  |                          | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 3308 Woodstock Ave.    |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME |   |  |  |  |                        |  |
| First Middle Last  |  |  | First Middle Last        |   |  |  |  |                        |  |
| Samuel Denbow  |  |  | Sena Martin              |   |  |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.   |                          | 17. INFORMANT Address   |  |  |  |                        |  |
| No   |  | 212-09-1454  |                          | Mildred E. Denbow, 3308 Woodstock Ave.  |  |  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Sepsis and congestive heart failure<br>1570 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 157X (b) Multiple hepatic abscesses<br>DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of head of pancreas |  |  |                          |   |  |  |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |                          |   |  |  |  |                        |  |
| Arteriosclerotic cardiovascular disease  |  |  |                          |   |  |  |  |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                        |  |
|  |  |  |                          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | Yes  |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |                        |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/27, 1968, to 4/21, 1968, that (I) (we) last saw the deceased alive on 4/21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |                          |   |  |  |  |                        |  |
| 22b. SIGNATURE<br>John E. Adams  |  |  |                          | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br>4/21/68  |  |                        |  |
| 22d. PHYSICIAN'S NAME (Type)<br>John E. Adams, M.D.  |  |  |                          | 22e. ADDRESS<br>6701 N. Charles Street  |  |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)                        |  |                        |  |
| Burial   |  | 4-25-68  |                          | Mt. Zion  |  | Harford Co., Md.   |  |                        |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |                          | 25a. REC'D BY REGISTRAR<br>DATE   |  | 25b. REGISTRAR'S SIGNATURE   |  |                        |  |
| Leonard J. Ruck, Inc., 5305 Harford Rd.  |  |  |                          | APR 23 1968   |  | Charles J. J...  |  |                        |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |                                      |   |  |   |                                   |  |                  |  |
|---|--|--|--|---|--------------------------------------|---|--|---|-----------------------------------|--|------------------|--|
| CERTIFICATE OF DEATH  |  |  |  |   |                                      |   |  |   |                                   |  |                  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |   |                                      | 2a. DATE OF DEATH   |  |   | 2b. HOUR                          |  |                  |  |
| Mary. E. DeWitt   |  |  |  |   |                                      | Month 4 Day 4 Year 68   |  |   | M                                 |  |                  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |                                      |   | 6. AGE (In years lost birthday)  |   | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS. |  |
| Female  |  | White  |  | 12/13/90  |                                      |   | 77 YRS.  |   | MONTHS                            |  | DAYS HOURS MIN   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                      | 9. COUNTY OF DEATH  |  |   |                                   |  |                  |  |
| Ill.  |  | U.S.A.   |  |   |                                      | Baltimore, Balto. Md.   |  |   |                                   |  |                  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                                      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |                  |  |
| Baltimore   |  |  | Balto. Cnty. Gen. Hosp.  |   |                                      | housewife   |  |   | homemaker                         |  |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN                    |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER            |  |                  |  |
| Md.   |  |  | Balto.   |   | Balto.                               |   |  |   | 3505 St. James Rd.                |  |                  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |   |                                      |   |  |   |                                   |  |                  |  |
| First Middle Last   |  |  | First Middle Last  |   |                                      |   |  |   |                                   |  |                  |  |
| William NMI Jones   |  |  | Julia NMI Price  |   |                                      |   |  |   |                                   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT                        |   |  |   |                                   |  |                  |  |
| No  |  |  | 332-14-7400  |   | BCGH Hosp. Record - 5401 Old Ct. Rd. |   |  |   |                                   |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac insufficiency</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Cardiomegaly 525 gm</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Severe arteriosclerosis</i>                                |  |  |  |   |                                      |   |  |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Months</i><br><i>YRS - Months</i><br><i>YRS</i> |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>443 Pulmonary atelectasis</i>  |  |  |  |   |                                      |   |  |   |                                   |  |                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |                                      | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>   |                                   |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                      |   |  |   |                                   |  |                  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                      |   |  |   |                                   |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on <i>11-PM, 4-49-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |                                      |   |  |   |                                   |  |                  |  |
| 22b. SIGNATURE<br><i>Angelita A. Topacio</i>  |  |  |  |   |                                      | DEGREE  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                                   | 22c. DATE SIGNED<br><i>4-4-68</i>  |                  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>ANGELITTA A - TOPACIO</i>  |  |  |  |   |                                      | 22e. ADDRESS<br><i>BCDH</i>   |  |   |                                   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                      | 23d. LOCATION (City or Town) (County) (State)   |  |   |                                   |  |                  |  |
| Burial  |  | 4/10/68  |  | Mt. Sterling City Cem.  |                                      | Mt. Sterling, Illinois  |  |   |                                   |  |                  |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |   |                                      | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |                                   |  |                  |  |
| Mitchell-Wiedefeld Home 6500 York Road<br>Baltimore, Md. 21212  |  |  |  |   |                                      | DATE <i>APR 10 1968</i>   |  | <i>Charles Judge</i>  |                                   |  |                  |  |

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

1. The first step is to identify the problem or question that needs to be answered.

1925-26

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1-1-33

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and send them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |  |  |   |  |  |  |  |  |                                   |  |  |  |
|--|--|--|--|---|--|--|--|--|--|-----------------------------------|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  | First  |  | Middle  |  | Last   |  | 2a. DATE OF DEATH  |  |                                   |  | 2b. HOUR                                     |  |
| Ellen C. Dolan   |  |  |  |   |  |  |  | April Month 13 Day 1968 Year   |  |                                   |  | M  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |  |  | 6. AGE (In years last birthday)                                      |  | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS.                             |  |
| F  |  | Cauc.  |  | June 23, 1893   |  |  |  | 74 YRS.  |  | MONTHS DAYS                       |  | HOURS MIN                                    |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  | Md.                               |  |  |  |
| Ireland  |  | U.S.A.   |  |   |  | Baltimore  |  |  |  |                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| Towson   |  | 8356 Loch Raven Blvd   |  |   |  | Housewife  |  |  |  |                                   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |                                   |  |  |  |
| Md.  |  | Baltimore  |  | Towson  |  | #  |  | 8356 Loch Raven Blvd.  |  |                                   |  |  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  | Address  |  |                                   |  |  |  |
| First Middle Last  |  |  |  | First Middle Last   |  |  |  |  |  |                                   |  |  |  |
| Owen Craig   |  |  |  | ??  |  |  |  |  |  |                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  |  |  |  |  |                                   |  |  |  |
| No   |  | R.R.Ret.   |  | C. Vincent Dolan, 8356 Loch Raven Blvd. 21204   |  |  |  |  |  |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |  |  |  |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u>   |  |  |  |   |  |  |  |  |  |                                   |  | Sudden                                       |  |
| 4129 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |   |  |  |  |  |  |                                   |  | ?  |  |
| (b) <u>Arteriosclerosis Cardiovascular disease</u>   |  |  |  |   |  |  |  |  |  |                                   |  |  |  |
| (c) <u>Emphysema of lung.</u>  |  |  |  |   |  |  |  |  |  |                                   |  | 2 weeks                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |  |  |   |  |  |  |  |  |                                   |  |  |  |
| 4330   |  |  |  |   |  |  |  |  |  |                                   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                   |  |  |  |
|  |  |  |  |   |  |  |  |  |  |                                   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |                                   |  |  |  |
|  |  | HOUR A.M. Month Day Year   |  |   |  |  |  |  |  |                                   |  |  |  |
|  |  | P.M. 19  |  |   |  |  |  |  |  |                                   |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION   |  | Street or R.F.D. No.   |  | City or Town   |  | County                            |  | State  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |   |  |  |  |  |  |                                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/22, 1967, to 4/13, 1968, that (I) (we) last saw the deceased alive on 4/11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |                                   |  |  |  |
| 22b. SIGNATURE   |  |  |  |   |  |  |  |  |  |                                   |  | 22c. DATE SIGNED                             |  |
| Joseph S. Blum MD  |  |  |  |   |  |  |  |  |  |                                   |  | 4/15/68                                      |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |   |  |  |  |  |  |                                   |  | 22e. ADDRESS                                 |  |
| JOSEPH S. BLUM MD  |  |  |  |   |  |  |  |  |  |                                   |  | 115 N. CALVERT ST                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)   |  | (County)   |  | (State)                           |  |  |  |
| Burial   |  | 4-16168  |  | Dulaney Valley Memorial   |  | Cockeysville, Balto,   |  | Md.  |  |                                   |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |                                   |  |  |  |
| Wm. Cook-Brooks Towson, Towson, Md.  |  |  |  |   |  | APR 17 1968  |  | Charles Judge  |  |                                   |  |  |  |

MEDICAL CERTIFICATION

2232

MADE IN GERMANY

02330

7

408 1 1968

MADE IN GERMANY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |                                 |  |
|---|--|--|--|---|--|---|--|---------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |                                 |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |                                 |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  | Middle  | Lost   | 2a. DATE OF DEATH   |  |                                 | 2b. HOUR   |
| Irene   |  |  | Ida  | Doran   | Month 4 Day 29 Year 1968   |   |  | 2:22 PM                         |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |   | 6. AGE (In years last birthday)                                      |                                 | IF UNDER 1 YEAR<br>MONTHS DAYS   |
| Female  |  | White  |  | August 19, 1892   |  |   | 75 YRS.  |                                 | IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH   |                                 |  |
| Joppa, Md.  |  | USA  |  |   |  |   | Baltimore, County Md.  |                                 |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                                 | 12b. KIND OF BUSINESS OR INDUSTRY  |
| Towson  |  |  | St Joseph Hospital   |   |  | Housewife   |  |                                 | home   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE   |  |  | 13b. COUNTY  |   |  | 13c. CITY OR TOWN   |  |                                 | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| Md.   |  |  | Harford  |   |  | Joppa   |  |                                 | 13e. STREET AND NUMBER   |
|   |  |  |  |   |  | 402 Philadelphia Road,  |  |                                 | Joppa, Md.   |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |   |  |   |  |                                 |  |
| First Middle Lost   |  |  | First Middle Lost  |   |  |   |  |                                 |  |
| Carl August Anderson  |  |  | Barbara Sophia Fisher  |   |  |   |  |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |   |  | 17. INFORMANT   |  |                                 |  |
| No  |  |  | 219-42-5170  |   |  | Barbara D. Johnson, 319 Phila Rd, Joppa, Md.  |  |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebro vascular Accident</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertensive Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   |  |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u><br><u>20 years</u>          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><u>443X</u>   |  |  |  |   |  |   |  |                                 |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |                                 |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August 1958</u> , to <u>April 29, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 29, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (the) (did not) view the body after death.  |  |  |  |   |  |   |  |                                 |  |
| 22b. SIGNATURE <u>Dr. Littleton</u>   |  |  |  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   |  | 22c. DATE SIGNED <u>4-29-68</u> |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Dr Littleton</u>  |  |  |  |   | 22e. ADDRESS <u>1012 Old Northpoint Rd</u>   |   |  |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   | 23d. LOCATION (City or Town) (County) (State)                        |                                 |  |
| Burial  |  | May 2, 1968  |  | Trinity Lutheran Cemetery   |  |   | Joppa Harford Md   |                                 |  |
| 24. FUNERAL DIRECTOR <u>Howard K. McComas &amp; Son, Abingdon, Md.</u>  |  |  |  |   | 25a. RECEIVED BY REGISTRAR<br>DATE <u>MAY 01 1968</u>  |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                      |                                 |  |

45331

INVESTIGATION

10026

RECEIVED  
CUSTOMS  
JAN 10 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A 15 (2)  
30M REV. 1/78

| <div style="display: flex; justify-content: space-between;"> <div> <p>05222</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH<br/>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> </div> <div> <p>05226</p> </div> </div> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p>  |  |  |  |   |  |  |   |   |  |   |   |
|---|--|--|--|---|--|--|---|---|--|---|---|
| 1. DECEASED-NAME (Type or print) <b>Sarah A DUVALL</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>5</b> Year <b>1968</b>  |   |   | 2b. HOUR<br><b>8:15AM</b>                        |   |   |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>May 4, 1887</b>  |  |  | 6. AGE (In years last birthday)<br><b>80</b> YRS. |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |   | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b> |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore, Md.</b>  |   |   |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. JOSEPH HOSPITAL</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Homemaker</b>                            |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>6600 Eastern Parkway</b> |   |
| 14. FATHER'S NAME First Middle Last<br><b>Franklin P. Jarvis</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Catherine Lucretia</b>   |  |  |   |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>219-12-7282</b>  |  | 17. INFORMANT<br><b>Mr George H Duvall</b>   |   |   | Address<br><b>Same</b>                           |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pleural effusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hodgkin paraganuloma</b><br>201X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                     |  |  |  |   |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>201X   |  |  |  |   |  |  |   |   |  |   |   |
| 19a. DATE OF OPERATION<br><b>3/5/68</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Intra-abdominal tumor</b> |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |   |  |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)     |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |   |  |   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>2/29/</b> 19 <b>68</b> , to <b>4/5/</b> 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>4/5/</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |   |  |   |   |
| 22b. SIGNATURE<br><i>Rafael Hernandez</i>   |  |  |  |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>April 5, 1968</b>  |  |   |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Rafael Hernandez, M.D.</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>  |   |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/8/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>  |   |   |  |   |   |
| 24. FUNERAL DIRECTOR<br><b>Leonard J Ruck Inc.</b>  |  |  |  |   |  | ADDRESS<br><b>Baltimore, Maryland</b>  |   | 25a. REC'D BY REGISTRAR<br><b>APR 9 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>    |   |

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

|   |                         |  |  |
|---|-------------------------|--|--|
| 05223   |                         | 05227  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>First</b> ANTHONY <b>Middle</b> JOSEPH <b>Last</b> ECKHARDT  |                         | 2a. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>13</b> Year <b>1968</b>                                     |  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br><b>August 16, 1935</b>   |  |
| 6. AGE (In years last birthday)<br><b>32</b> YRS.   |                         | IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN.                                    |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |                         | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson 4</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |  |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>MR</b>  |                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>LOAN CO</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>  |  |
| 13c. CITY OR TOWN<br><b>ESSEX</b>   |                         | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 13e. STREET AND NUMBER<br><b>1050 Foxwood Lane #21</b>  |                         |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>ANTHONY M. ECKHARDT</b>   |                         | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>P</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>UNK</b> (If yes give war or dates of service)   |                         | 16b. SOCIAL SECURITY NO.<br><b>216-32-1255</b>   |  |
| 17. INFORMANT<br><b>MARY ECKHARDT</b>   |                         | Address<br><b>ABOVE</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1950</b> IMMEDIATE CAUSE (a) <b>Abdominal Carcinomatosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                  |                         |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>1992</b>  |                         |  |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                         | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                       |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |                         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |                         |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |
| 21f. LOCATION Street or R.F.D. No. City or Town County State  |                         |  |  |
| 22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>January 23, 1968</b> , to <b>April 13, 1968</b> , that <del>it</del> (we) last saw the deceased alive on <b>April 13, 1968</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) (did) (did not) view the body after death. |                         |  |  |
| 22b. SIGNATURE<br><b>Vichian Phupakdi</b>   |                         | 22c. DATE SIGNED<br><b>April 13, 1968</b>  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Vichian Phupakdi, M.D.</b>  |                         | 22e. ADDRESS<br><b>7620 York Rd. 21204</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>4/16/68</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL</b>  |                         | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>J.G. CONNELLY SONS</b>   |                         | 25a. REC'D BY REGISTRAR<br><b>APR 16 1968</b>  |  |
| ADDRESS<br><b>300 MACE</b>  |                         | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1883

1883

1883



1883

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                  |                  |  |  |  |  |   |                      |   |  |  |  |   |                   |  |
|--|--|------------------|------------------|--|--|--|--|---|----------------------|---|--|--|--|---|-------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |                  |  |  |  |  |   |                      |   |  |  |  |   |                   |  |
| 1. DECEASED-NAME<br>(Type or Print)  |  |                  | First<br>Lillian |  |  | Middle<br>J.   |  |   | Last<br>Eichelberger |   |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> <input checked="" type="checkbox"/> Month Day Year 1968<br>Apr. 9, 1968 |  |   | 2b. HOUR<br>179 M |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White |                  | 5. DATE OF BIRTH<br>Jan. 28, 1911  |  | 6. AGE (in years<br>last birthday)<br>57 YRS                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |                      | IF UNDER 24 HRS<br>HOURS MIN.                                   |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year 1968<br>April 9, 1968   |  |   | 2d. HOUR<br>134 M |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   |  |                  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                      |   |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |  |   |                   |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk   |  |                  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>4 Bayside Drive |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Housewife   |                      |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY U. S. A.  |  |   |                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE Md.   |  |                  |                  | 13b. COUNTY Baltimore  |  |  |  | 13c. CITY OR TOWN Dundalk   |                      |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET AND NUMBER<br>4 Bayside Drive       |                   |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Harry Granruth   |  |                  |                  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Edith Smith |  |   |                      |   |  |  |  |   |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No  |  |                  |                  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>213-36-3074                   |  |  |  | 17. INFORMANT (Husband)<br>Mr. Samuel D. Eichelberger, Jr.  |                      |   |  | ADDRESS Dundalk, Md.<br>4 Bayside Dr.  |  |   |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4129 A-S-C-V Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.  |  |                  |                  |  |  |  |  |   |                      |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                  |                  |  |  |  |  |   |                      |   |  |  |  |   |                   |  |
| 19a. DATE OF OPERATION<br>4221   |  |                  |                  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED  |  |  |  |   |                      |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |                   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  |                  |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                                       |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                      |   |  |  |  |   |                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                  |                  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)                    |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                      |   |  |  |  |   |                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/><br>6800 Mornington Rd.<br>ACTUAL SIGNATURE M.B. Davis M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b. DATE SIGNED<br>EXAMINER'S NAME (Type) Melvin B. Davis M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 9, 1968<br>ADDRESS (Street, city, town, or county) Dundalk, Md. 21222 |  |                  |                  |  |  |  |  |   |                      |   |  |  |  |   |                   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  |                  |                  | 23b. DATE<br>4/12/68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery      |  |   |                      | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md. |  |  |  |   |                   |  |
| 24. FUNERAL DIRECTOR<br>John J. Duda, 7922 Wise Ave. Dundalk, Md.  |  |                  |                  |  |  | 25a. REC'D BY REGISTRAR<br>DATE APR 15 1968                  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |                      |   |  |  |  |   |                   |  |

13222

RECEIVED

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NOV 1951

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a memorandum or official letter.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05225  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
 Item 9 Film G399 4/16/68 kk  
 CERTIFICATE OF DEATH

05229

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>BALTIMORE</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write nearest town)<br><b>Catonsville</b>  |  | c. LENGTH OF STAY IN b.<br><b>9 months</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>7106 Rolling Road Apt. A 27</b>   |  | d. STREET ADDRESS <b>BALTIMORE, MD 21227</b><br><b>7106 ROLLING RD APT A</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>NORMA</b> Middle <b>ANNA</b> Last <b>EUKER</b>   |  | 4. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>1</b> Year <b>1968</b>  |   |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4/2/1879</b>   |
| 9. AGE (In years last birthday)<br><b>189/88 yrs.</b>  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   | 11. IF UNDER 24 HRS.<br>Months Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>BALTIMORE, MD</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>LEANDRO ECKEMDIA</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>SARAH ?</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT <b>DAUGHTER</b> Address <b>7106 ROLLING RD</b><br><b>AUDREY L. FEADER BALTIMORE MD 21227</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>410.0</b><br>DUE TO <b>Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>PREMATURE VENTRICULAR CONTRACTION.</b><br>DUE TO<br>(c) <b>Rt MYOCARDIAL INFARCTION.</b> |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>420.1</b>  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12/26</b> , 19 <b>66</b> , to <b>4/1</b> , 19 <b>68</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>3/23</b> , 19 <b>68</b> , and that death occurred at <b>7:40 P.M.</b> , from causes and on the date stated above.  |  |   |   |
| 22a. SIGNATURE<br><b>E. KASARI'S, M.D.</b>   |  | 22b. DATE SIGNED<br><b>4/1/68</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>E. KASARI'S, (M.D.)</b>   |  | 22d. ADDRESS<br><b>1801 FREDERICK RD BALTO * 21228</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>4/3/68</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                            |
| 24. FUNERAL DIRECTOR<br><b>Wm. Fickner &amp; Sons</b>  |  | 25a. REC'D BY REGISTRAR<br><b>APR 5 - 1968</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |   |

05230

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05230

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

22a film 40 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 7a, 7b & 8

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05230

|  |  |                         |  |  |  |   |  |  |  |   |  |   |  |
|--|--|-------------------------|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print) First Middle Last<br><b>AUDREY LILLIAN FEADER</b>  |  |                         | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> Month Day Year<br><b>4-21-1968</b> |  |  | 2b. HOUR<br>M<br><b>10:10</b>   |  |  |  |   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br><b>1-28-09</b>   |  | 6. AGE (In years<br>last birthday) <b>59</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>April 21 1968</b>   |  | 2d. HOUR<br>M<br><b>10:10</b>                                     |  |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Balto. Md.</b>   |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> |   |  | Md.                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>7106-A Rolling Rd.</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)   |  |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY      |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Md.</b>  |  |                         |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER<br><b>7106-A Rolling Road</b>              |  |   |  |
| 14. FATHER'S NAME First Middle Last<br><b>Alfred A. Euker</b>  |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Norma Anna</b>   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  |                         |  | 16b. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT<br>ADDRESS   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4129 Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)  |  |                         |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>4221</b>   |  |                         |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)                              |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |                         |  |  |  |   |  |  |  |   |  |   |  |
| ACTUAL<br>SIGNATURE<br><b>Charles S. Springate</b><br>EXAMINER'S<br>NAME (Type)  |  |                         |  | M.D.<br><b>Charles S. Springate, M.D.</b>  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  |   |  | 22b. DATE SIGNED<br><b>April 22, 1968</b> |  |
| 23a. BURIAL, CREMATION<br>REMOVAL (Specify)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>4/23/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>William J. Tickner</b>  |  |                         |  |  |  | ADDRESS<br><b>Balto. Md.</b>  |  | 25a. REGD. BY REGISTRAR<br>DATE<br><b>MAY 10 1968</b>  |  | 25b. REGD. BY SIGNATURE<br><b>John J. Judge</b>                   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

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VR A 5-14  
30M REV 7-68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |   |  |                                   |  |
|--|--|--|--|--|--|---|---|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |   |  |                                   |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |   |  |                                   |  |
| 1. DECEASED-NAME (Type or print) <b>PHILIP A. FELICETTI</b>  |  |  |  |  | 2a. DATE OF DEATH <b>4/13/68</b>   |   |   | 2b. HOUR <b>M</b>                                      |                                   |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH <b>7/31/12</b>  |  | 6. AGE <b>55</b> years (lost boy) YRS. MONTHS DAYS                                      |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |                                   |  |
| 7a. BIRTHPLACE (State or foreign country) <b>BALTO. Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>BALTO. Md.</b>  |   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>BALTO. CO. GEN. HOSP. BARBER</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>BALTO. CO.</b>  |  |  | 13b. COUNTY <b>RANDALLSTOWN</b>  |  | 13c. CITY OR TOWN <b>#</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET AND NUMBER <b>8803 SONYA RD. RANDALLSTOWN</b> |  |                                   |  |
| 14. FATHER'S NAME First Middle Last <b>ANTONIO FELICETTI</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>GRACE LOMBARDI</b>   |   |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, state war or dates of service) <b>YES</b>  |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>220-05-0031</b>  |   |   |  |                                   | 17. INFORMANT Address <b>MRS. MARGUERITE FELICETTI 8803 SONYA RD. RANDALLSTOWN</b> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4109</b> IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>A.S.H.D.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> |  |  |  |  |  |   |   |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201</b>  |  |  |  |  |  |   |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |   |   |  |                                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |   |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/6</b> , 19 <b>66</b> , to <b>present</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>3/7</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |   |  |                                   |  |
| 22b. SIGNATURE <b>Bernard Bergen M.D.</b>  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED <b>4/15/68</b>   |  |                                   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>BERNARD BERGEN</b>   |  |  |  |  | 22e. ADDRESS <b>6721 RIESERTOWN RD. Md.</b>  |   |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 23b. DATE <b>4/16/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NATIONAL</b>  |  |   | 23d. LOCATION (City or Town) (County) (State) <b>BALTO. Md.</b>   |  |                                   |  |
| 24. FUNERAL DIRECTOR <b>Frank Della Noce</b>   |  |  |  | 322 S. HIGH ST.  |  | 25a. REC'D BY REGISTRAR <b>APR 16 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>        |                                   |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, 3 and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 10-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div>Items 21c, 22a film 400</div> <div>5-8-68 mt</div> <div>05228</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>05232</div>   |  |                         |  |                                   |  |   |  |  |   |  |  |
|--|--|-------------------------|--|-----------------------------------|--|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print)<br><b>FRANCIS Preston FENTON</b>   |  |                         | 2a. DATE KNOWN OF ESTI-DEATH MATED<br><input checked="" type="checkbox"/> Month Day Year<br><b>4-27 1968</b>   |                                   |  | 2b. HOUR<br><b>1:05 PM</b>  |  |  |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br><b>66 YRS</b> |  | 6. AGE (In years last birthday)<br><b>66 YRS</b>  |  | 7c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>April 27, 1968</b>    |   | 2d. HOUR<br><b>1:05 PM</b>                   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>G.B. M. C.</b>              |                                   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Homemaker</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  |                         | 13b. COUNTY<br><b>Baltimore</b>  |                                   |  | 13c. CITY OR TOWN<br><b>Brooklandville</b>  |  |  | 13d. INSIDE CITY LIMITS?<br><input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><b>Valley Rd. "Brandonwood"</b>  |  |                         | 14. FATHER'S NAME<br>First Middle Last<br><b>Harry J. Carroll</b>  |                                   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Susan Preston</b>   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |  |                         | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)  |                                   |  | 17. INFORMANT<br><b>Foster T. Fenton</b>  |  |  | ADDRESS<br><b>Above</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Blunt injuries of trunk</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>987X</b><br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                         |  |                                   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>1955</b>   |  |                         |  |                                   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>1955</b>  |  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                   |  |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br><b>10:52 AM 4-27 1968</b>                                 |                                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)<br><b>Jumped or fell from 2nd floor</b>                                     |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK  |  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Sheppard Pratt Hospital</b> |                                   |  | 21f. LOCATION Street or R.F.D. No.<br><b>Towson Baltimore Md.</b>   |  |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |                         |  |                                   |  |   |  |  |   |  |  |
| ACTUAL SIGNATURE<br><b>Charles S. Springate</b>  |  |                         | EXAMINER'S NAME (Type)<br><b>Charles S. Springate, M.D.</b>  |                                   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  | 22b. DATE SIGNED<br><b>April 28, 1968</b>   |  |  |
|  |  |                         |  |                                   |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |   |  |  |
|  |  |                         |  |                                   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  |  |   |  |  |
|  |  |                         |  |                                   |  | ADDRESS (Street, city, town, or county)   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                         | 23b. DATE<br><b>4-29-68</b>  |                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b> |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville Md.</b> |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto.</b>  |  |                         |  |                                   |  | 25a. REC'D BY REGISTRAR<br><b>MAY 2 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                     |   |  |  |

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|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AT 5 (4)  
30M REV. 1/68

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 05233  |  |   |  |
|--|--|---|--|--|--|--|--|--|--|---|--|
| 05223  |  |   |  | CERTIFICATE OF DEATH   |  |  |  | 05233  |  |   |  |
| 1. DECEASED-NAME (Type or print) <b>JAMES NELSON FESMYER</b>   |  |   |  | 2a. DATE OF DEATH <b>Month 4 / Day 10 / Year 68</b>  |  |  |  | 2b. HOUR <b>11 A. M.</b>   |  |   |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>white</b>  |  | 5. DATE OF BIRTH <b>7/3/1890</b>   |  |  |  | 6. AGE (In years last birthday) <b>77</b> YRS.                                     |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country) <b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore County, Md.</b>  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson State Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Plumber</b> |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>   |  | 13b. COUNTY <b>Queen Annes</b>  |  | 13c. CITY OR TOWN <b>Centerville</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 13e. STREET AND NUMBER <b>101 S. Liberty St.</b>                                   |  |   |  |
| 14. FATHER'S NAME First Middle Last <b>Joseph Fesmyer</b>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Catherine Harper</b>                                       |  |  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO. <b>216-12-1469</b>   |  | 17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the lung.</b><br>1621<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>163X</b> |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?               |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/22/1968</b> to <b>4/10/1968</b> , that (I) (we) lost the deceased on <b>4/10/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>William Newcomer</b>   |  |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  |  |  | 22c. DATE SIGNED   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>   |  |   |  | 22e. ADDRESS <b>Mount Wilson, Maryland</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 23b. DATE <b>April 12, 1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Chesterfield Cemetery</b>  |  |  |  | 23d. LOCATION (City or Town) (County) (State) <b>Centerville, Queen Annes, Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR <b>James H. Baiter, Jr., Baiter Bros., Centerville, Md. 21617</b>   |  |   |  | 25a. REC'D BY REGISTRAR <b>DATE APR 16 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A154  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |   |                                     |   |  |   |
|--|--|---|-------------------------------------|---|--|---|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>KENNARD W. FISHER   |  | 2a. DATE OF DEATH<br>Month Day Year<br>April 9, 1968  |                                     | 2b. HOUR<br>6:00 PM   |  |   |
| 3. SEX<br>Male   | 4. RACE<br>White                       | 5. DATE OF BIRTH<br>12-8-1893   |                                     | 6. AGE (In years<br>lost birthday)<br>74 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    | IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br>Baltimore Md. |   |  |   |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>415 Overbrook Road   |                                     | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Retired |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Catonsville    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       | 13e. STREET AND NUMBER<br>415 Overbrook Road |   |
| 14. FATHER'S NAME First Middle Last<br>Howard Fisher   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Agnes M. Mohrman  |                                     |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or (unknown) (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.  |                                     | 17. INFORMANT Address<br>Mrs. Marie E. Fisher, 415 Overbrook Rd.                                      |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion, acute</u><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic C - V. Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Postural Hypotension</u><br>4201 |  |   |                                     |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>Sudden<br>years      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |                                     |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |                                     | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                       |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)   |                                     | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 1960, to April, 1968, that (I) (we) last saw the deceased alive on March 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |   |                                     |   |  |   |
| 22b. SIGNATURE<br>Dr. Leo Gaver  |  |   |                                     | 22c. DATE SIGNED<br>April 10, 1968  |  | 22d. PHYSICIAN'S<br>NAME (Type)<br>Dr. Leo Gaver                        |
| 22e. ADDRESS<br>1 Mallow Hill Rd., Balto., Md.   |  | 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL  |                                     |   |  |   |
| 23b. DATE<br>4-12-1968   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery  |                                     | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore County, Maryland                           |  |   |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Howard H. Hubbard, 4107 Wilkens Ave. 21229  |  |   |                                     | 25a. REC'D BY REGISTRAR<br>DATE<br>APR 16 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                             |

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Figure 1

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

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05235

|   |  |   |   |  |   |  |  |  |  |
|---|--|---|---|--|---|--|--|--|--|
| 1. DECEASED-NAME (Type or print) <b>HARRY</b>   |  |   | First Middle Last   |  | 2a. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>29</b> Year <b>1968</b>            |  | 2b. HOUR <b>4:15</b> M <b>PM</b>                                     |  |  |
| 3. SEX <b>MALE</b>  |  | 4. RACE <b>WHITE</b>  |   | 5. DATE OF BIRTH<br><b>[REDACTED]</b>  |   | 6. AGE (In years lost birthday) <b>78</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.    |  |
| 7a. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>BALTIMORE</b> County Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>BALTIMORE COUNTY GEN. HOSP.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>TAILOR</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>   |  | 13b. COUNTY <b>[REDACTED]</b>   |   | 13c. CITY OR TOWN <b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>5905 PARK HEIGHTS AVE</b>        |  |
| 14. FATHER'S NAME First Middle Last <b>ABRAHAM FLAY</b>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last <b>SARAH ?</b> |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO. <b>218-32-5890</b>   |   | 17. INFORMANT Address <b>MRS. DOROTHY GROSSMAN, 5905 PARK HEIGHTS AVE.</b>   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c-))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>COMPLETE HEART BLOCK</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIO SCLEROTIC HEART DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION <b>4-30-68</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                    |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 28, 1968</b> , to <b>April 29, 1968</b> , that (I) (we) last saw the deceased alive on <b>April 29, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |   |  |  |  |  |
| 22b. SIGNATURE <b>Josefina T. Naraval MD</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |   |   |  |   |  |  | 22c. DATE SIGNED <b>April 29, 1968</b>                     |  |
| 22d. PHYSICIAN'S NAME (Type) <b>JOSEFINA T. NARAVAL, MD</b>   |  |   |   |  |   |  |  | 22e. ADDRESS <b>BALTIMORE COUNTY GEN. HOSP.</b>            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  | 23b. DATE <b>4-30-68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>BETH TFILOH</b>  |   | 23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>                     |  |  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>  |  |   |   | ADDRESS  |   | 25a. REC'D BY REGISTRAR <b>MAY 2 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF TEXAS

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IN SENATE, FEBRUARY 1, 1907.

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE.

RECEIVED BY THE COMMISSIONER OF THE GENERAL LAND OFFICE.

RECEIVED BY THE COMMISSIONER OF THE GENERAL LAND OFFICE.

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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |  |   |   |  |  |  |  |
|---|--|--|---|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  | First  | Middle  | Last  | 2a. DATE OF DEATH<br>Month Day Year  |  | 2b. HOUR                                 |  |
| BEULAH  |  | A.   |   | FOWLER  | APRIL 29, 1968   |  | 4:00 AM                                  |  |
| 3. SEX  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |  |
| FEMALE  | NEGRO  |  | JUNE 14, 1904   |   | 63 YRS.  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  | Md.                                      |  |
| MARYLAND  | U.S.A.   |  |   |   | BALTIMORE  |  |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| TOWSON  | ST. JOSEPH HOSPITAL  |  | HOMEMAKER   |   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                   |  |
| MARYLAND  | BALTIMORE  |  |   |   |  |  | 717 E. 22nd ST. #21218                   |  |
| 14. FATHER'S NAME   | First  | Middle   | Last  | 15. MOTHER'S MAIDEN NAME  |  | First  | Middle                                   | Last   |
| William   |  | Montford   |   | Jane  |  | Snowden  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |  | Address  |  |  |
|   |  | 215-32-2792  |   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Uremia<br>1820<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hepatic failure<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Endometrial carcinoma - Stage IV<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>172x |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                      |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from APRIL 24, 1968, to APRIL 29, 1968, that (X) (we) lost saw the deceased alive on APRIL 29, 1968, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |   | 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |
| Jaime Punzalan  |  | 4-29-68  |   | Jaime Punzalan, M.D.  |  |  |  |  |
| 22e. ADDRESS  |  | 22f. ADDRESS   |   |   |  |  |  |  |
| 7620 York Road, Towson, Md. 21204   |  | 7620 York Road, Towson, Md. 21204  |   |   |  |  |  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)                        |  |  |
| Burial  |  | May 4, 1968  |   | Mt. Calvary Cemetery  |  | A.A. County, Md.   |  |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |
| Robert Williams   |  | 1701-03 N. Bond St. 21213  |   | MAY 1 1968  |  | Charles Judge  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05233

05237

|  |  |   |   |   |  |   |  |   |   |                               |   |  |
|--|--|---|---|---|--|---|--|---|---|-------------------------------|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Myrtle Kathryn France   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>4 9 68                                   |   |  | 2b. HOUR<br>7:45 PM   |  |   |   |                               |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Cau  |   | 5. DATE OF BIRTH<br>2/28/1943/28/04   |  | 6. AGE (In years<br>last birthday)<br>64 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                        |   | IF UNDER 24 HRS.<br>HOURS MIN |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |   |                               |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Greater Balto. Med. Center |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired)<br>Clerk, Dept. Store   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |   |   |                               |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  | 13e. STREET AND NUMBER<br>3207 Bayonne Ave.                     |   |                               |   |  |
| 14. FATHER'S NAME First Middle Last<br>George R. McGinnity   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Catherine Lampe                   |   |  |   |  |   |   |                               |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No   |  |   | 16b. SOCIAL SECURITY NO.<br>214-30-4696   |   |  | 17. INFORMANT Address<br>Mrs. Doris Buckler, 8725 Satyr Hill Rd.  |  |   |   |                               |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma of right breast with metastases<br>174X<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. |  |   |   |   |  |   |  |   |   |                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>170X  |  |   |   |   |  |   |  |   |   |                               |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? yes |                               |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |                               |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |                               |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 9, 1968, to April 9, 1968, that (I) (we) last<br>saw the deceased alive on April 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |   |   |                               |   |  |
| 22b. SIGNATURE<br>R. Breiteneker, M.D.   |  |   | DEGREE  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br>4/10/68   |                               |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>R. Breiteneker, M.D.  |  |   | 22e. ADDRESS<br>6701 N. Charles Street  |   |  |   |  |   |   |                               |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  |   | 23b. DATE<br>4/13/68  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cemetery |   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md. |   |                               |   |  |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck, Inc., Balto. Md. 21214  |  |   | 25a. REC'D BY REGISTRAR<br>DATE APR 11 1968                                     |   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |   |   |                               |   |  |

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|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Pikesville</u>  |  | c. LENGTH OF STAY IN 1b<br><u>17 Hawthorne Ave., Pikesville 8, Md.</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>17 Hawthorne Ave., Pikesville 8, Md.</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Sadie Jane Fritz</u>  |  | 4. DATE OF DEATH<br>Month Day Year<br><u>April 16, 1968</u>   |  |
| 5. SEX<br><u>Female</u>  |  | 6. COLOR OR RACE<br><u>White</u>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><u>May 12, 1872</u>   |  |
| 9. AGE (In years last birthday)<br><u>95</u> yrs.  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>own home</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Roxbury, Pa.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>William Musser</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Adelaide Powell</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |  |
| 17. INFORMANT<br><u>Mrs. Adeline Valentine</u>   |  | Address: <u>Pikesville 8, Md.</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST (Slow Rate for 4 years)</u><br>4129<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <u>AFTER 10 SCLEROTIC C.V. DISEASE</u><br>DUE TO (c) <u>4 YEARS</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 YEARS</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>4330</u>   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                               |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>48</u> , to <u>APRIL 16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov. 15 1967</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.   |  |   |  |
| 22a. SIGNATURE<br><u>Martin E. Strobel</u>   |  | 22b. DATE SIGNED<br><u>APRIL 16, 1968</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>MARTIN E. STROBEL</u>   |  | 22d. ADDRESS<br><u>FEISTERS-WAY MD.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE THEREOF<br><u>April 19, 1968</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Druid Ridge Cemetery</u>  |  | 23d. LOCATION (City, town or county) (State)<br><u>Pikesville 8, Md.</u>  |  |
| 24. FUNERAL DIRECTOR<br><u>Frank H. Newell</u>   |  | 25a. REC'D BY REGISTRAR<br><u>APR 24 1968</u>   |  |
| ADDRESS<br><u>Pikesville 8, Md.</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>James J. Jones</u>   |  |

VR A15 (4)  
20M 1/65

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[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| <div style="display: flex; justify-content: space-between;"> <span>05235</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH<br/>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>05239</span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>   |  |   |   |   |                                     |   |   |   |  |  |  |  |  |
|---|--|---|---|---|-------------------------------------|---|---|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>HOWARD</b> <b>EDWARD</b> <b>FRYE</b>   |  |   |   | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>24</b> Year <b>68</b>  |                                     |   |   | 2b. HOUR<br><b>10:50 PM</b>   |  |  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br><b>6/7/10</b>   |                                     |   |   | 6. AGE (In years last birthday)<br><b>57</b> YRS.                           |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign)<br><b>PENNSYLVANIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY,</b> Md.  |   |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET. ADMINISTRATION HOSPITAL</b> |   |                                     | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>TRUCK DRIVER</b>  |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BALTO COUNTY</b> |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>DUNDALK</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>205 GOLGATE AVENUE</b>      |  |  |  |  |
| 14. FATHER'S NAME<br>First <b>HOWARD</b> Middle <b>FRYE</b> Last <b>FRYE</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>First <b>SABINA</b> Middle <b>DAVIS</b> Last <b>DAVIS</b>   |                                     |   |   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no or unknown <b>YES</b> (If yes give war or dates of service) <b>WW II</b>  |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>216 03 79 69</b>   |                                     | 17. INFORMANT<br>Address <b>CLIN.REC.VA HOSPITAL, FT HOWARD, MD.</b>  |   |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST WITH ACUTE CORONARY OCCLUSION, POSSIBLE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>DIABETES MELLITUS</b><br>2509<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>260X<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |   |   |   |                                     |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   |                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>               |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                     |   |   |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                     |   |   |   |  |  |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>3/16/68</b> , 19__, to <b>4/24/68</b> , 19__, that (2) (we) last saw the deceased alive on <b>4/24/68</b> , 19__, and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (we) (did) (did not) view the body after death.  |  |   |   |   |                                     |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Ahmed Kutty</b>  |  |   |   |   |                                     | DEGREE <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4/25/68</b>  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>AHMED C. K. KUTTY, M. D.</b>   |  |   |   |   |                                     | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4/29/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL CEMETERY</b>  |                                     |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b> |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>ULLRICH FUNERAL HOME</b><br>ADDRESS<br><b>2112 DUNDALK AVE. BALTIMORE, MD.</b>   |  |   |   |   |                                     | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 29 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                          |  |  |  |  |  |

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*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-74  
30M REV. 7/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05236

05240

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Katherine Sarah Gaffney</b>  |   | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>5</b> Year <b>1968</b>   |   | 2b. HOUR<br><b>2:10</b> M.  |  |
| 3. SEX<br><b>female</b>   | 4. RACE<br><b>white</b>   | 5. DATE OF BIRTH<br><b>Oct. 1, 1892</b>   |   | 6. AGE (In years last birthday)<br><b>75</b> YRS.                         | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SPRING GROVE STATE HOSP.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>housewife</b> | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Balto.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        | 13e. STREET AND NUMBER<br><b>215 S. Augusta Avenue</b>                    |  |
| 14. FATHER'S NAME First Middle Last<br><b>C. Lee Brown</b>  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Sarah Agnes</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or (unknown) (If yes give war or dates of service)   |   | 16b. SOCIAL SECURITY NO.<br><b>218-22-7865</b>  |   | 17. INFORMANT Address<br><b>Records: SPRING GROVE STATE HOSPITAL</b>      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure.</b><br><b>4409</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Generalized arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>4500</b>   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   | 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)    |   |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State              |  |
| 22a. I certify that (this hospital) attended the deceased from <b>Oct. 8, 1964</b> to <b>April 5, 1968</b> , that (I) (we) last saw the deceased alive on <b>April 5, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Dr. Paul L. Machado</b>  |   | 22c. DATE SIGNED<br><b>4/5/68</b>   |   | 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Paul L. Machado</b>                |  |
| 22e. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>  |   | 22f. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |   | 23b. DATE<br><b>4-8-68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b>       |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Balto., Md.</b>   |   | 23e. LOCATION (City or Town) (County) (State)<br><b>Balto., Md.</b>   |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Witzke Funeral Directors, Balto., Md. 21229</b>  |   | 25a. REC'D BY REGISTRAR<br><b>APR 9 - 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                          |  |

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CERTIFICATE OF DEATH

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|--|--|--|---|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (Type or print) <b>Thomas</b>   |  |  | First <b>Thomas</b> Middle <b>Arlington</b> Last <b>Gambrill</b>                                      |  |  | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>8</b> Year <b>1968</b>  |  |   | 2b. HOUR <b>4 p M</b>  |  |  |
| 3. SEX <b>Male</b>   |  |  | 4. RACE <b>White</b>  |  |  | 5. DATE OF BIRTH<br><b>June 29, 1905</b>   |  |   | 6. AGE (In years last birthday) <b>62 63</b> YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH <b>Baltimore</b> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Balto. 34</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7909 Oakdale Ave.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Supervisor</b>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |  |  | 13b. COUNTY <b>Balto.</b>   |  |  | 13c. CITY OR TOWN <b>Balto. 34</b>   |  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER <b>7909 Oakdale Ave.</b>  |  |  | 14. FATHER'S NAME First <b>William</b> Middle <b>B.</b> Last <b>Gambrill</b>                          |  |  | 15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Kelly</b> Last <b>Kelly</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO. <b>213 07 3422</b>   |  |  | 17. INFORMANT Address <b>Mrs. Margaret Gambrill 7909 Oakdale Ave.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br><b>4109</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerosis, Generalized</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes - ± 10 yrs.</b> |  |  |   |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201 None</b>   |  |  |   |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION <b>None</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                     |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1952</b> , to <b>8 April, 1968</b> , that (I) (we) lost saw the deceased alive on <b>13 Nov 1967</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE <b>Edward L. Molz</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |   |  |  |  |  | 22c. DATE SIGNED <b>4-9-68</b>                          |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Dr. Edward L. J. Molz</b>  |  |  |   |  |  |  |  | 22e. ADDRESS <b>7425 Harford Road. Balto. Md. 21214</b> |  |  |  |
| 23a. BURIAL, CREMATION, REINTERMENT <b>Burial</b>  |  |  | 23b. DATE <b>4-10-68</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH CEMETERY</b>  |  |   | 23d. LOCATION (City or Town) (County) (State) <b>Balto. Co. Maryland</b>                     |  |  |
| 24. FUNERAL DIRECTOR ADDRESS <b>Wm. E. Johnson, 8521 Loch Raven Blvd. 21204</b>  |  |  |   |  |  | 25a. RECEIVED BY REGISTRAR <b>APR 11 1968</b>  |  |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |  |  |   |  |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 05238  |  |  |  |   |  | 05242  |  |  |  |   |  |
| 1. DECEASED-NAME (Type or print) <b>James F. Garvey, Sr.</b>   |  |  |  |   |  | 2a. DATE OF DEATH <b>April 12, 1968</b>  |  |  |  | 2b. HOUR <b>M</b>   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH <b>May 28, 1892</b>  |  | 6. AGE (In years last birthday) <b>75</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |  | IF UNDER 24 HRS.<br>HOURS MIN.                                    |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore County, Md.</b>  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Catonsville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>501 N. Rolling Rd.</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Wholesale Plumbing Supplied</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>                        |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Catonsville</b>  |  | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                               |  | 13e. STREET AND NUMBER <b>501 N. Rolling Road</b>                    |  |   |  |
| 14. FATHER'S NAME First <b>James</b> Middle <b>Garvey</b> Last   |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Higgins</b> Last   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>none</b>   |  | 16b. SOCIAL SECURITY NO. <b>218-32-4733</b>  |  | 17. INFORMANT Address <b>Mrs Gertrude I. Garvey 501 N. Rolling Rd.</b>  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>410.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Generalized Art. Sclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 hrs.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>  |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec</b> , 19 <b>60</b> , to <b>April</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>March 7</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>J. Sheldon Eastland M.D.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  |   |  | 22c. DATE SIGNED <b>4/12/68</b>  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>J. Sheldon Eastland M.D.</b>   |  |  |  |   |  | 22e. ADDRESS <b>Medical Arts Bldg., Balto., Md.</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE <b>4/16/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery-Baltimore, Maryland</b>  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR <b>Sterling Funeral Estate</b> ADDRESS <b>1936 Edmondson Ave., Catonsville, Md. 21228</b>   |  |  |  |   |  | 25a. REC'D BY REGISTRAR DATE <b>APR 16 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                      |  |   |  |

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05239 CERTIFICATE OF DEATH 05243

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>                |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>TOWSON</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>TOWSON</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Chesapeake Manor Nursing Home</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>TASSEA S. GEORGE</b>   |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>20</b> Year <b>1968</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 24, 1897</b> |
| 9. AGE (In years last birthday) <b>70</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Kythera, Greece</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Harris Christopher Souris</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Beulah Kyprion</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service) <b>NONE</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>-</b>   |  |
| 17. INFORMANT<br><b>Theodore George</b>  |                                  | Address<br><b>Cedar Ave., Towson, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Rupture of aortic abdominal aneurysm</b><br><b>4412</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(Diagnosed 1965)</b><br><b>Arteriosclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Coronary artery disease</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH.<br><b>30 min</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Oct 24</b> , 19 <b>58</b> , to <b>April 20</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>April 14</b> , 19 <b>68</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.   |                                  |   |  |
| 22a. SIGNATURE<br><b>George T. Gilmore</b>   |                                  | 22b. DATE SIGNED<br><b>April 22, 1968</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>GEORGE T. GILMORE</b>   |                                  | 22d. ADDRESS<br><b>1717 YORK RD, LUTHERVILLE MD</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>Apr. 23, 1968</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Erect Orthodox Cemetery</b>   |                                  | 23d. LOCATION (City, town or county) (State)<br><b>Woodlawn, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>John Burns' Sons, Towson, Md.</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                  | DATE<br><b>APR 25 1968</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |  |   |  |  |   |  |                               |
|---|--|---|---|---|--|---|--|--|---|--|-------------------------------|
| CERTIFICATE OF DEATH  |  |   |   |   |  |   |  |  |   |  |                               |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First Middle Last<br>Margaret Eva Gessler   |   |  | 2a. DATE OF DEATH<br>Month 4 Day 15 Year 68   |  |  | 2b. HOUR<br>6-0 A M   |  |                               |
| 3. SEX<br>F   |  | 4. RACE<br>W  |   | 5. DATE OF BIRTH<br>12-1-1892   |  |   | 6. AGE (In years<br>last birthday)<br>75 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                    |  | IF UNDER 24 HRS.<br>HOURS MIN |
| 7a. BIRTHPLACE (State or foreign<br>country) Baltimore, Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |   |  |                               |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>21 Dunvale Rd. 21204 |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Housewife |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                              |  |                               |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE Md.  |  |   | 13b. COUNTY Baltimore   |   | 13c. CITY OR TOWN<br>Towson  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>(11)                                    |  |                               |
| 14. FATHER'S NAME First Middle Last<br>Augustus Reuwer  |  |   |   |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Barbra Neuberg                         |   |  |  |   |  |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  |   | 16b. SOCIAL SECURITY NO.<br>212 40 6277   |   | 17. INFORMANT Address<br>Elizabeth A. Carpenter, Balto. 21093                        |   |  |  |   |  |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br><u>4120</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic Heart Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Essential Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>Instant</u> |  |                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>443X</u>   |  |   |   |   |  |   |  |  |   |  |                               |
| 19a. DATE OF OPERATION<br>—   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—                           |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? —            |  |   |  |                               |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |   |  |  |   |  |                               |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |   |  |  |   |  |                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , to <u>April 15, 1968</u> , that (I) <del>(we)</del> lost<br>saw the deceased alive on <u>January 19, 1968</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the<br>causes stated above, (I) <del>(we)</del> <u>(did)</u> <del>(did not)</del> view the body after death.                |  |   |   |   |  |   |  |  |   |  |                               |
| 22b. SIGNATURE<br><u>Keith A. Manley MD</u>   |  | DEGREE  |   | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>                    |  | 22c. DATE SIGNED<br><u>4-16-68</u>  |  |  |   |  |                               |
| 22d. PHYSICIAN'S<br>NAME (Type) <u>KEITH A. MANLEY</u>  |  | 22e. ADDRESS <u>2045, YORK ROAD, TOWSON, MD.</u>                                |   |   |  |   |  |  |   |  |                               |
| 23a. BURIAL, CREMATION,<br>REMOVAL <u>Burial</u>  |  | 23b. DATE<br><u>4-18-68</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Baltimore Nat.</u>   |  |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, # Md.</u>             |  |   |  |                               |
| 24. FUNERAL DIRECTOR<br><u>Wm. Cook-Brooks Towson, Towson, Md. 21204</u>  |  |   |   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>APR 18 1968</u>                                   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                   |  |   |  |                               |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 05241  |  | 05245   |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Morris NMI Goldberg  |  | 2a. DATE OF DEATH Month Day Year<br>April 23, 1968  |  | 2b. HOUR 11 PM   |  |
| 3. SEX Male  |  | 4. RACE <del>XXXXXX</del> -White  |  | 5. DATE OF BIRTH Feb. 11, 1900   |  |
| 6. AGE (In years lost birthday) 68 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (State or foreign country) Md.  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |
| 9. COUNTY OF DEATH Baltimore Co.   |  | Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH Randallstown, Md.  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore Co. Gen.   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CLERK  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY FOOD   |  | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.   |  | 13b. COUNTY Balto.   |  |
| 13c. CITY OR TOWN Randallstown   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET AND NUMBER 3702 Allenswood Ct.   |  |
| 14. FATHER'S NAME First Middle Last<br>Abraham Goldberg  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>ELIZABETH Goldberg  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO. 212-22-1326  |  | 17. INFORMANT MRS. LILLIAN BERNHARD, 3702 ALLENSWOOD CT. #21133  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4129 Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Arteriosclerotic Cardiovascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>7221 |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  | 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |
| 21f. LOCATION Street or R.F.D. No. City or Town County State   |  | 22a. I certify that (I) (this hospital) attended the deceased from 4/21, 1968, to 4/23, 1968, that (I) (we) last saw the deceased alive on 4/23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE Fausto Q. Aquino, Jr. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. DATE SIGNED 4-24-68 |  |
| 22d. PHYSICIAN'S NAME (Type) FAUSTO Q. AQUINO, JR.   |  | 22e. ADDRESS c/o BALTIMORE COUNTY GEN. HOSPITAL   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL   |  | 23b. DATE 4-25-68   |  | 23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM   |  |
| 23d. LOCATION (City or Town) BALTIMORE, MARYLAND   |  | (County)  |  | (State)  |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN ROAD, BALTO. 21215  |  | 25a. REC'D BY REGISTRAR DATE APR 29 1968  |  | 25b. REGISTRAR'S SIGNATURE Charles Judge   |  |

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>IRENE L. GORE</b>   |  | First Middle Last  |  | 2a. OATE OF DEATH<br>Month Day, Year <b>APRIL 3, 1968</b>   |  | 2b. HOUR<br><b>1:30<sup>a</sup> PM</b>  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>1-5-06</b>   |  | 6. AGE (In years last birthday)<br><b>62</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SUMMIT NURSING HOME</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOMEMAKER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>CATONSVILLE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>9 N. BELLEGROVE RD.</b>   |  | 14. FATHER'S NAME First Middle Last<br><b>WALTER HORTON</b>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>LILLIAN</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>  |  | 17. INFORMANT Address<br><b>LEROY W. GORE 9 N. BELLEGROVE RD. 21228</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the colon with</b><br><b>1538</b> DUE TO, OR AS A CONSEQUENCE OF <b>metastatic melanoma</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>1538</b>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/14</b> , 19 <b>68</b> , to <b>4/3</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/2</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>E. Kasaitis M.D.</b>  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>4/4/68</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>EDMUND KASAITIS</b>   |  |  |  | 22e. ADDRESS<br><b>1801 FREDERICK RD.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4-6-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WOODLAWN CEMETERY</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>WOODLAWN, BALTO. CO., MD.</b>               |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>HOWARD H. HUBBARD 4107 WILKENS AVE. 21229</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 10 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas Judge</b>   |  |

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|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 05243   |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |   |  | 05247   |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>ALICE GERTRUDE GRIBBIN  |  |  |  |   |  | 2a. DATE OF DEATH<br>Month Day Year<br>4 25 68  |  | 2b. HOUR<br>6:22 AM                                      |  |
| 3. SEX<br>F   |  | 4. RACE<br>Can.  |  | 5. DATE OF BIRTH<br>2/2/93  |  | 6. AGE (In years lost birthday)<br>75 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                |  |
| 7a. BIRTHPLACE (State or foreign country)<br>BALTO., MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTO. Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>GR. BALTO. MED. CENTER             |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>H.W.   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>OWN HOME   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MD.  |  | 13b. COUNTY<br>BALTO   |  | 13c. CITY OR TOWN<br>BALTO  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>436 E. 28 <sup>th</sup> Street |  |
| 14. FATHER'S NAME First Middle Last<br>NICHOLAS D. LEBRUN   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>ALICE J. MOONEY  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>220-54-6787  |  | 17. INFORMANT<br>(P+5 HISTORY) EUGENE N. GRIBBIN<br>Address 2518 CANTERBURY Rd  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u><br>4120 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertensive cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Cirrhosis of liver with jaundice</u><br>443X<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>443X |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>yes                     |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 14</u> , 19 <u>68</u> , to <u>APRIL 25</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>APRIL 25</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>T.C. Cullis MD  |  | DEGREE<br>MD   |  | ATTENDING PHYS.<br><input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS.<br><input type="checkbox"/>                       |  | 22c. DATE SIGNED<br>APRIL 25-1968   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>T.C. CULLIS MD  |  | 22e. ADDRESS<br>Greater Balto. Medical Center  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>4/29/68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.                                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>H. W. Jenkins & Sons Co.  |  | ADDRESS<br>1905 York Rd.<br>Balto. 12, Md.   |  | 25a. REC'D BY REGISTRAR<br>DATE<br>APR 26 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |  |

05253

05253

CERTIFICATE OF DEATH

|          |     |     |      |               |                |               |                |                |                |                 |                  |
|----------|-----|-----|------|---------------|----------------|---------------|----------------|----------------|----------------|-----------------|------------------|
| 1        | 2   | 3   | 4    | 5             | 6              | 7             | 8              | 9              | 10             | 11              | 12               |
| NAME     | AGE | SEX | RACE | DATE OF BIRTH | PLACE OF BIRTH | DATE OF DEATH | PLACE OF DEATH | CAUSE OF DEATH | DATE OF BURIAL | PLACE OF BURIAL | NAME OF MINISTER |
| NICHOLAS | 62  | M   | W    | 1887          | MD             | 1948          | MD             | HEART DISEASE  | 1948           | MD              | W. W. HOGAN      |
| LEBRON   | 62  | M   | W    | 1887          | MD             | 1948          | MD             | HEART DISEASE  | 1948           | MD              | W. W. HOGAN      |
| ALICE    | 62  | F   | W    | 1887          | MD             | 1948          | MD             | HEART DISEASE  | 1948           | MD              | W. W. HOGAN      |

220-07-087 144 HISTORY

*Anterior for dilation  
Hypertensive with cerebral disease*

*Condition of heart not favorable*

9

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05244

05248

|   |  |  |   |   |  |   |   |   |  |  |
|---|--|--|---|---|--|---|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Bessie Montague Brown Griswold</b>   |  |  | 2a. DATE OF DEATH<br><b>April</b> Month <b>19</b> Day <b>1968</b> Year                            |   |  | 2b. HOUR<br><b>12<sup>30</sup>AM</b>  |   |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>June 11, 1886</b>  |  | 6. AGE (In years last birthday)<br><b>81</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. 12</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>7 Montrose</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Balto. 12</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>7 Montrose Ave.</b> |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Alexander Brown</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Bessie Montague</b>                           |   |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>220-44-7177</b>  |   | 17. INFORMANT<br>Address<br><b>Jl Alexander B. Griswold Monkton, Md.</b>             |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Arteriosclerosis</b><br><b>437.9</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>generalized &amp; cerebral arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>331X</b> |  |  |   |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |   | County State  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1946</b> , to <b>April</b> , 19 <b>68</b> , that (I) (we) lost the deceased alive on <b>April 18</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Walter B. Buck MD</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |   |   |  | 22c. DATE SIGNED<br><b>4/19/68</b>  |   |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>WALTER B. BUCK</b>   |  |  |   |   |  | 22e. ADDRESS<br><b>18 E. EAGER ST, BALTO 21202</b>  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4-22-68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. James</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Co. Md.</b>                                      |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto.</b>  |  |  |   |   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 22 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>              |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |   |  |   |  |   |                                |                                |  |
|--|--|---|--|---|--|---|--|---|--|---|--------------------------------|--------------------------------|--|
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  |   |                                |                                |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First<br>MABEL   |   |  | Middle<br>E.  |  | Last<br>GUERKE  |  | 2a. DATE OF DEATH<br>April Month 26, Day 1968 <sup>Year</sup> |                                | 2b. HOUR<br>8:55 <sup>PM</sup> |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>August 21, 1882   |  |   | 6. AGE (In years<br>lost birthday)<br>85 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                   |   | IF UNDER 24 HRS.<br>HOURS MIN. |                                |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore   |  |   | Md.  |   |                                |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Summit Nursing Home |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Housewife |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY             |   |                                |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before<br>admission) STATE<br>Maryland   |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Baltimore             |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>816 N. Woodington Road |   |                                |                                |  |
| 14. FATHER'S NAME<br>First<br>John   |  |   | Middle<br>Callis   |   | Last<br>Mary                               |   | 15. MOTHER'S MAIDEN NAME<br>First<br>Pickett   |   |  | Middle<br>Ave.  |                                |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  |   | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                                      |   | 17. INFORMANT<br>Mr. Robert D. Guerke, Jr. |   |  | Address<br>2216 Westchester   |  |   | Ave.                           |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular</u><br><u>4129</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>disease with Gr. IV degeneration</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>&amp; Coronary Insufficiency &amp; Anemia</u> |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH               |                                |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>4201</u>  |  |   |  |   |  |   |  |   |  |   |                                |                                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |   |                                |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |   |                                |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |   |                                |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 28, 1958</u> , to <u>Apr. 26, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Apr. 25, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |   |  |   |                                |                                |  |
| 22b. SIGNATURE<br><u>Harry L. Knipp</u> M.D.   |  | 22c. DATE SIGNED<br><u>4-27-68</u>  |  | ATTENDING<br>PHYS.<br><input checked="" type="checkbox"/>   |  | MED.<br>DIRECTOR<br><input type="checkbox"/>  |  | STAFF<br>PHYS.<br><input type="checkbox"/>                              |  | 22e. ADDRESS<br>4116 Edmondson Ave., Balto., Md.              |                                |                                |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Dr. Harry L. Knipp  |  |   |  |   |  |   |  |   |  |   |                                |                                |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>4-29-1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |  |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                 |   |  |   |                                |                                |  |
| 24. FUNERAL DIRECTOR<br>Howard H. Hubbard, 4107 Wilkens Ave. 21229   |  |   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE<br>APR 29 1968  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                      |  |   |                                |                                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |               |  |                                    |   |   |  |   |  |                                 |  |
|--|--|---------------|--|------------------------------------|---|---|--|---|--|---------------------------------|--|
| 05246  |  |               |  |                                    |   |   |  |   |  | 05250                           |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |               | First  |                                    | Middle  |   | Last   |   | 2a. DATE OF DEATH  |                                 | 2b. HOUR                                     |
| MARY J. HAMILTON   |  |               |  |                                    |   |   |  |   | Month 4 Day 25 Year 68   |                                 | 5 A.M.                                       |
| 3. SEX   |  | 4. RACE       |  | 5. DATE OF BIRTH                   |   |   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| female   |  | white         |  | March 23, 1887                     |   |   |  | 81 YRS.   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |               | 7b. CITIZEN OF WHAT COUNTRY?   |                                    |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                                 |  |
| Whiteford, Md.   |  |               | U. S.  |                                    |   |   |  | Baltimore Md.   |  |                                 |  |
| 10. CITY OR TOWN OF DEATH  |  |               | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                    |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                                 |  |
| Catonsville  |  |               | SPRING GROVE STATE HOSP.   |                                    |   |   | Housewife  |   |  |                                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |               | 13b. COUNTY  |                                    | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER   |                                 |  |
| Md.  |  |               | Harford  |                                    | Whiteford   |   |  |   | Flintville Road  |                                 |  |
| 14. FATHER'S NAME  |  |               | First  |                                    | Middle  |   | Last   |   | 15. MOTHER'S MAIDEN NAME   |                                 |  |
| Harry  |  |               | Hughes   |                                    |   |   |  |   | Jane Hughes  |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)   |  |               | 16b. SOCIAL SECURITY NO.   |                                    |   | 17. INFORMANT Address   |  |   |  |                                 |  |
| No   |  |               | 220-54-8935  |                                    |   | Records: SPRING GROVE STATE HOSPITAL  |  |   |  |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |               |  |                                    |   |   |  |   |  |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>  |  |               |  |                                    |   |   |  |   |  |                                 | <u>MIN</u>                                   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>MYOCARDIAL INFARCTION</u>   |  |               |  |                                    |   |   |  |   |  |                                 | <u>8 hours</u>                               |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>  |  |               |  |                                    |   |   |  |   |  |                                 | <u>YEARS</u>                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |               |  |                                    |   |   |  |   |  |                                 |  |
| <u>4201 OLD AGE</u>  |  |               |  |                                    |   |   |  |   |  |                                 |  |
| 19a. DATE OF OPERATION   |  |               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                    |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |               | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |   |  |                                 |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>   |  |               | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |  |   |  |                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 17, 1968</u> , to <u>April 25, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 25, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  |               |  |                                    |   |   |  |   |  |                                 |  |
| 22b. SIGNATURE <u>Narciso Aristigueta</u> M.D. DEGREE  |  |               |  |                                    |   |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <u>4-25-68</u> |  |
| 22d. PHYSICIAN'S NAME (Type) <u>NARCISO ARISTIGUETA</u>  |  |               |  |                                    |   |   |  | 22e. ADDRESS <u>SPRING GROVE STATE HOSPITAL.</u>  |  |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE     |  | 23c. NAME OF CEMETERY OR CREMATORY |   |   | 23d. LOCATION (City or Town) (County) (State)  |   |  |                                 |  |
| Burial   |  | Apr. 27, 1968 |  | Tabernacle                         |   |   | Whiteford, Harford, Md.  |   |  |                                 |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |               |  |                                    |   | 25a. REC'D BY REGISTRAR DATE  |  | 25b. REGISTRAR'S SIGNATURE  |  |                                 |  |
| John H. Harbina, DELTA, PA.  |  |               |  |                                    |   | APR 29 1968   |  | Charles Judge   |  |                                 |  |

MEDICAL CERTIFICATION

03556

03556

DATE: 4-22-68

TIME: 10:00 AM

LOCATION: SPRING GROVE STATE HOSPITAL

REASON: CHRONIC ARREST

PHYSICIAN: DR. J. H. BROWN

DIAGNOSIS: BACTERIOLOGICAL INFECTION

TESTS: 8 hours

TREATMENT: 4-22-68

PROGNOSIS: CHRONIC ARREST

REMARKS: BACTERIOLOGICAL INFECTION

SIGNATURE: J. H. BROWN

DATE: 4-22-68

TIME: 10:00 AM

LOCATION: SPRING GROVE STATE HOSPITAL

REASON: CHRONIC ARREST

PHYSICIAN: DR. J. H. BROWN

DIAGNOSIS: BACTERIOLOGICAL INFECTION

TESTS: 8 hours

TREATMENT: 4-22-68

PROGNOSIS: CHRONIC ARREST

REMARKS: BACTERIOLOGICAL INFECTION

SIGNATURE: J. H. BROWN

DATE: 4-22-68

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

|   |  |  |  |   |  |   |  |  |  |                                   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|-----------------------------------|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  | First  |  | Middle  |  | Last  |  | 2a. DATE OF DEATH  |  |                                   |  | 2b. HOUR                                     |  |
| Estelle M. Harris   |  |  |  |   |  |   |  | Month Day Year<br>APRIL 24 68  |  |                                   |  | 5:00 AM                                      |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |   |  | 6. AGE (In years last birthday)                                      |  | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS.                             |  |
| Female  |  | W  |  | 10-16-79  |  |   |  | 88 YRS.  |  | MONTHS DAYS                       |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. COUNTY OF DEATH   |  |                                   |  | Md.  |  |
| Maryland  |  | U. S. A.   |  | WIDOWED   |  | DIVORCED  |  | Baltimore  |  |                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| Baltimore   |  | Summitt Nursing H.   |  |   |  |   |  |  |  |                                   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER   |  |                                   |  |  |  |
| Maryland  |  |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 1020 Woodington Rd. (21229)  |  |                                   |  |  |  |
| 14. FATHER'S NAME   |  | First  |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME   |  | First                             |  | Middle Last                                  |  |
| Christian   |  |  |  |   |  | Mason   |  | Elizabeth  |  |                                   |  | Downing                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  |   |  | 1020 Woodington Rd. Balto., Md. 21229                                |  |                                   |  |  |  |
| No  |  |  |  | Mrs. May Mantler, Balto., Md. 21229   |  |   |  |  |  |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |   |  |  |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |   |  |   |  |  |  |                                   |  |  |  |
| IMMEDIATE CAUSE (a) Cerebral Thrombosis   |  |  |  |   |  |   |  |  |  |                                   |  |  |  |
| 4129 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |  |  |                                   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis  |  |  |  |   |  |   |  |  |  |                                   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardio-Vasc. Disease  |  |  |  |   |  |   |  |  |  |                                   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |  |  |  |                                   |  |  |  |
| 4221  |  |  |  |   |  |   |  |  |  |                                   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                   |  |  |  |
|   |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  |  |  |                                   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |   |  |  |  |                                   |  |  |  |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | HOUR A.M. Month Day Year<br>P.M. 19  |  |   |  |   |  |  |  |                                   |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION   |  |   |  | Street or R.F.D. No.   |  | City or Town                      |  | County State                                 |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  |  |   |  |   |  |  |  |                                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 10, 1966, to Apr. 24, 1968, that (I) (we) last saw the deceased alive on Apr. 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |                                   |  |  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  |   |  | 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  | 22f. ADDRESS                      |  |  |  |
| Harry L. Knipp, MD  |  | 4-24-68  |  |   |  | Dr. HARRY Knipp   |  | 4116 Edmondson Ave. 21229  |  |                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)  |  | (County)   |  | (State)                           |  |  |  |
| Burial  |  | 4-26-68  |  | Western Cemetery  |  | Balto., Md.   |  |  |  |                                   |  |  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. REC'D BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |                                   |  |  |  |
| 4101 Edmondson Avenue<br>Witzke Funeral Directors, Balto., Md. 21229  |  | DATE APR 25 1968   |  |   |  | J. Charles Judge  |  |  |  |                                   |  |  |  |

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |
| 1. DECEASED-NAME (Type or print)   |  |  | First Middle Last                          |  |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
| PAUL RADCLIFFE HARTMAN SR.   |  |  |  |  |  | Month Day Year<br>APRIL 20, 1968  |  | 10:50PM  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN                 |  |
| MALE   |  | WHITE  |  | 11/27/97   |  | 70  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |  |
| MARYLAND   |  | U.S.A.   |  |  |  | BALTIMORE   |  | Md.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| FORT HOWARD  |  | VETERANS ADMIN. HOSPITAL   |  | SELF-EMPLOYED  |  | CONSTRUCTION  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  | 13e. STREET AND NUMBER   |  |
| MARYLAND   |  | BALTIMORE  |  | Dundalk  |  |   |  | 3506 LOUTH ROAD  |  |
| 14. FATHER'S NAME First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last |  |  |   |  |  |  |
| ISAAC - - HARTMAN  |  |  | Volear Davis                               |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address   |  |  |  |
| YES  |  | WWII   |  | 212 20 06 76   |  | CLINICAL RECORDS, VAH, FT. HOWARD, MD.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PULMONARY CONGESTION AND EDEMA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CARDIOMEGALY<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ARTERIOSCLEROTIC HEART DISEASE                          |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>DAYS<br>YEARS<br>YEARS |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4200 PATCHY BRONCHOPNEUMONIA   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |  |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town  |  | County State   |  |
| 22a. I certify that (a) (this hospital) attended the deceased from APRIL 17, 1968, to APRIL 20, 1968, that (a) (we) last saw the deceased alive on APRIL 20, 1968, and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (not) view the body after death. |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  | DEGREE  |  | 22c. DATE SIGNED   |  |
| MARIO S. QUIROS, M.D.  |  |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 4 21 68  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  | 22e. ADDRESS  |  |  |  |
| MARIO S. QUIROS, M.D.  |  |  |  |  |  | VAH, FT. HOWARD, MD.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |
| BURIAL   |  | 4/24/68  |  | BALTIMORE NATIONAL   |  | BALTIMORE MARYLAND  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  | 25a. REC'D BY REGISTRAR DATE   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| DUDAS FUNERAL HOME, 7922 WISE AVE BALTO MD   |  |  |  | APR 24 1968  |  | Charles Judge   |  |  |  |

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br>CERTIFICATE OF DEATH   |   |  |  | 05253   |   |
|--|---|--|--|---|---|
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>Pauline Hartung</b>   |   |  | 2a. DATE OF DEATH Month Day Year<br><b>April 14, 1968</b>          |   | 2b. HOUR<br>M   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>W</b>                           | 5. DATE OF BIRTH<br><b>Sept. 17, 1886</b>  |  | 6. AGE (In years last birthday) YRS.<br><b>81</b>   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                         |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO. CO. MD</b>  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Summitt Nursing Home</b>  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>702 Braeside Road</b> |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>Balto.</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>                              | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        | 13e. STREET AND NUMBER<br><b>3624 Edmondson Avenue</b>  |
| 14. FATHER'S NAME First Middle Last<br><b>Henry Hartung</b>  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Pauline Hagan</b> |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>215-10-5329</b>   |  | 17. INFORMANT<br><b>Dorothy Ashburn, Balto., Md. 21229</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b><br><b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CARCINOMA - PANCREAS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos.</b><br><b>18 mo -</b> |   |  |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>157X</b>  |   |  |  |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |   | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                     |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 1, 1968</b> , to <b>APRIL 14, 1968</b> , that (I) (we) lost saw the deceased alive on <b>APRIL 13, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |  |  |   |   |
| 22b. SIGNATURE<br><b>Norman R. Kleinman</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |   |  |  | 22c. DATE SIGNED<br><b>4/15/68</b>  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>NORMAN R. KLEIMAN</b>   |   |  |  | 22e. ADDRESS<br><b>3803 EDMONDSON AVE -</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |   | 23b. DATE<br><b>4-18-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oaklawn Cemetery</b>   |   |
| 23d. LOCATION (City or Town)<br><b>Balto., Md.</b>   |   | 23e. (County) (State)  |  | 23f. (County) (State)   |   |
| 24. FUNERAL DIRECTOR<br><b>Wit zke Funeral Directors, Balto., Md. 21229</b>  |   |  |  | 25a. REC'D BY REGISTRATION DATE<br><b>APR 17 1968</b>   |   |
| 25b. SIGNATURE<br><b>John J. Judge</b>   |   |  |  | 25c. SIGNATURE  |   |

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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

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|   |  |  |                   |   |   |   |  |  |                                |   |                               |  |
|---|--|--|-------------------|---|---|---|--|--|--------------------------------|---|-------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>SAMUEL P. HAUCK</b>  |  |  | First Middle Last |   | 2a. DATE OF DEATH<br><b>April 22, 1968</b>                                      |   |  | Month Day Year   |                                | 2b. HOUR<br><b>2AM</b>  |                               |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |                   | 5. DATE OF BIRTH<br><b>Oct. 16, 1900</b>  |   |   | 6. AGE (In years last birthday)<br><b>67</b>                         |  | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |                                |   |                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bowley's Quarters</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Rt. 15 Seneca Gardens Rd.</b> |                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Chauffeur</b>   |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Truck</b>                    |  |                                |   |                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |                   | 13c. CITY OR TOWN<br><b>Rural</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>Rt. 15 Seneca Gardens Rd.</b> |                                |   |                               |  |
| 14. FATHER'S NAME<br><b>William Hauck</b>   |  |  | First Middle Last |   |   | 15. MOTHER'S MAIDEN NAME<br><b>Lizetta Lochmiller</b>   |  |  | First Middle Last              |   |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service)<br><b>WWI</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218 10 5529A</b>  |                   | 17. INFORMANT<br><b>Hilda Hauck</b>   |   |   | Address<br><b>Same</b>   |  |                                |   |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic Coronary Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Auricular Fibrillation</b>                                    |  |  |                   |   |   |   |  |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 minutes</b><br><b>5 yrs</b><br><b>5 yrs</b> |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4201</b>  |  |  |                   |   |   |   |  |  |                                |   |                               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                |   |                               |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) |   |  |  |                                |   |                               |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                     |                   |   | 21f. LOCATION Street or R.F.D. No.  |   | City or Town   |  | County                         |   | State                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 10, 1963</b> , to <b>April 22, 1968</b> , that (I) (we) lost saw the deceased alive on <b>April 20, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                   |   |   |   |  |  |                                |   |                               |  |
| 22b. SIGNATURE<br><b>Joseph Pokorny MD</b>  |  | DEGREE   |                   | ATTENDING PHYS.<br><input checked="" type="checkbox"/>  |   | MED. DIRECTOR <input type="checkbox"/>  |  | STAFF PHYS. <input type="checkbox"/>                       |                                | 22c. DATE SIGNED<br><b>4/23/68</b>  |                               |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR JOSEPH POKORNY</b>  |  | 22e. ADDRESS<br><b>2206 E Madison St</b>   |                   |   |   |   |  |  |                                |   |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/25/68</b>  |                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |   |   | 23d. LOCATION (City or Town)<br><b>Baltimore Co., Md.</b>            |  | (County) (State)               |   |                               |  |
| 24. FUNERAL DIRECTOR<br><b>Bruzdinski Funeral Home</b>  |  |  |                   |   |   | ADDRESS<br><b>1407 Eastern Ave.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>APR 24 1968</b>              |                                | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                               |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |   |  |  |                                   |  |  |
|---|--|--|--|--|---|--|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |                                   |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |                                   |  |  |
| 1. DECEASED-NAME (Type or print)  |  |  | First Middle Last  |  |   | 2a. DATE OF DEATH  |  | 2b. HOUR                          |  |  |
| Marie Ruppertsberger Hawkins  |  |  |  |  |   | Month Day Year<br>April 29, 1968   |  | 2:45 M                            |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR                   |  |  |
| female  |  | white  |  | May 6, 1903  |   | 64 YRS.  |  | MONTHS DAYS HOURS MIN.            |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |                                   |  |  |
| Md.   |  | U. S. A.   |  |  |   | Baltimore  |  | Md.                               |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Catonsville   |  |  | SPRING GROVE STATE HOSP.   |  |   | housewife  |  | Own Home                          |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |  |
| Md.   |  |  | Pr. Geo. ✓   |  | Larchmont   |  | YES  |                                   | 2 Park Drive                                 |  |
| 14. FATHER'S NAME First Middle Last   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |   |  |  |                                   |  |  |
| George Gustave Ruppertsberger   |  |  |  | Mary Elizabeth Doberer   |   |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address   |  |  |                                   |  |  |
| no  |  |  | none   |  | Records: SPRING GROVE STATE HOSPITAL  |  |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction, acute, death,  |  |  |  |  |   |  |  |                                   | sudden (min)                                 |  |
| 410.9 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |   |  |  |                                   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201   |  |  |  |  |   |  |  |                                   |  |  |
| (b) Arteriosclerotic Cardiovascular Heart Dis   |  |  |  |  |   |  |  |                                   | 15 yrs.                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |   |  |  |                                   |  |  |
| (c) Arteriosclerosis, Generalized, senile.  |  |  |  |  |   |  |  |                                   | 15 yrs.                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |   |  |  |                                   |  |  |
| a) Obesity (270lbs.), exogenous; b) Diabetes Mellitus, age onset, mild.   |  |  |  |  |   |  |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |  |  |
|   |  |  |  |  |   |  |  |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |                                   |  |  |
|   |  |  |  |  |   |  |  |                                   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |   | City or Town   |  | County State                      |  |  |
|   |  |  |  |  |   |  |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 20 19 68, to April 29 19 68, that (I) (we) last saw the deceased alive on April 29 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |  |   |  |  |                                   |  |  |
| 22b. SIGNATURE  |  |  |  |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED                  |  |  |
| Anthony J. Young, M.D.  |  |  |  |  |   |  |  | 4-29-68                           |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |   | 22e. ADDRESS   |  |                                   |  |  |
| Spring Grove State Hospital   |  |  |  |  |   | Baltimore, Maryland 21228  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |                                   |  |  |
| Burial  |  | May 1, 1968  |  | Loudon Park Cemetery   |   | Baltimore Md. Balto. Md.   |  |                                   |  |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |  |   | 25a. REC'D BY REGISTRAR DATE   |  | 25b. REGISTRAR'S SIGNATURE        |  |  |
| Francis Gasch's Sons Hyattsville, Md.   |  |  |  |  |   | MAY 3 1968   |  | Charles Judge                     |  |  |





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |         |                  |  |                                |  |  |  |                          |  |  |           |
|---|---------|------------------|--|--------------------------------|--|--|--|--------------------------|--|--|-----------|
| 1. DECEASED-NAME<br>(Type or Print)   |         |                  | First Middle Last  |                                |  | 2a. DATE KNOWN OF ESTI-DEATH MATED   |  |                          | 2b. HOUR   |  |           |
| DOROTHY   |         |                  | HENRY  |                                |  | Month Day Year   |  |                          | 1968 6:35  |  |           |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS |  | IF UNDER 24 HRS.<br>HOURS MIN  |  | 2c. DATE PRONOUNCED DEAD |  |  | 2d. HOUR  |
| Female  | White   | 6-20-1916        | 51 YRS.  |                                |  |  |  | Month Day Year           |  |  | 1968 6:35 |
| 7a. BIRTHPLACE (State or foreign country)   |         |                  | 7b. CITIZEN OF WHAT COUNTRY?   |                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |                          | 9. COUNTY OF DEATH   |  |           |
| Indiana   |         |                  | U.S.A.   |                                |  |  |  |                          | Balto. Md.   |  |           |
| 10. CITY OR TOWN OF DEATH   |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |                                |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |                          | 12b. KIND OF BUSINESS OR INDUSTRY  |  |           |
| Balto.  |         |                  | 9525 Pulaski Highway   |                                |  | Housewife  |  |                          | Housewife  |  |           |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                  | 13b. CITY OR TOWN  |                                |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |                          | 13e. STREET AND NUMBER   |  |           |
| Md.   |         |                  | Balto.   |                                |  |  |  |                          | 9525 Pulaski Highway   |  |           |
| 14. FATHER'S NAME   |         |                  | 15. MOTHER'S MAIDEN NAME   |                                |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |                          | 16b. SOCIAL SECURITY NO.   |  |           |
| Edwin Little  |         |                  | Bernice Richardson   |                                |  | No   |  |                          | 383-07-6331  |  |           |
| 17. INFORMANT   |         |                  | ADDRESS  |                                |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |           |
| Mr Oakley E. Henry  |         |                  | 9525 Pulaski Highway   |                                |  | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Barbiturate ingestion</u><br>9500<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                          |  |  |           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |                  | 19a. DATE OF OPERATION   |                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                          | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |           |
| 9702  |         |                  |  |                                |  |  |  |                          |  |  |           |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |         |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M.  |                                |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)  |  |                          |  |  |           |
|   |         |                  | 4 23 19 68   |                                |  | Ingested barbiturates  |  |                          |  |  |           |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |         |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |                                |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |                          |  |  |           |
|   |         |                  | Home?  |                                |  | 9525 Pulaski Highway Balto. BALTO. Md.   |  |                          |  |  |           |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                                |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |                          | 22b. DATE SIGNED   |  |           |
| ACTUAL SIGNATURE  |         |                  | M.D.   |                                |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |                          | Deputy Medical Examiner <input type="checkbox"/>                                 |  |           |
| EXAMINER'S NAME (Type)  |         |                  | Edward F. Wilson, M.D.   |                                |  | ADDRESS (Street, city, town, or county)  |  |                          | April 24, 1968   |  |           |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |                  | 23b. DATE  |                                |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                          | 23d. LOCATION (City or Town) (County) (State)                                    |  |           |
| Burial  |         |                  | 4-27-1968  |                                |  | Grandville, Cemetery   |  |                          | Grandville, Michigan   |  |           |
| 24. FUNERAL DIRECTOR  |         |                  | ADDRESS  |                                |  | 25a. REC'D BY REGISTRAR  |  |                          | 25b. REGISTRAR'S SIGNATURE   |  |           |
| Lassahn Funeral Home  |         |                  | 7401 Belair Road   |                                |  | DATE APR 29 1968   |  |                          | Charles Judge  |  |           |

22523

22523

|                     |  |       |  |       |  |
|---------------------|--|-------|--|-------|--|
| Section             |  | Twp   |  | Range |  |
| County              |  | State |  | Date  |  |
| Description of land |  |       |  |       |  |
| Acres               |  |       |  |       |  |
| Remarks             |  |       |  |       |  |
| Surveyor            |  |       |  |       |  |
| Witness             |  |       |  |       |  |
| Agent               |  |       |  |       |  |
| Approved            |  |       |  |       |  |
| Special Agent       |  |       |  |       |  |
| Inspector           |  |       |  |       |  |
| Chief of Bureau     |  |       |  |       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05253

05257

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Balto.</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>City</b>                          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Randallstown</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>CHAPELL HILL NURSING HOME</b>   |   | d. STREET ADDRESS<br><b>Park Ave.</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Cora</b> Middle <b>E.</b> Last <b>Hoffacker</b>  |   | 4. DATE OF DEATH<br>Month <b>4</b> Day <b>10</b> Year <b>1968</b>   |   |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 13, 1886</b>   |
| 9. AGE (In years last birthday)<br><b>81</b> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>10</b> Hours <b>10</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Nurse</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Carroll Co. Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Elijah F. Hoffacker</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Jonna Hare</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |   | 16. SOCIAL SECURITY NO.<br><b>219-30-7068A</b>  |   |
| 17. INFORMANT<br><b>Mrs. Harry W. Armacost</b>   |   | Address<br><b>Reisterstown, Md.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>① Bronchopneumonia</b><br><b>485X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>② Aspiration due to Inability to swallow.</b><br>DUE TO<br>(c) |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>③ Chronic Brain Syndrome and Arteriosclerosis</b><br><b>491X</b>   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 1B.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>6-11-1967</b> , to <b>4-10-1968</b> , that (I) (we) last saw the deceased alive on <b>4-10-1968</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><b>Cesar Valle Caverio</b>   |   | 22b. DATE SIGNED<br><b>4-10-68</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>CESAR VALLE CAVERO</b>  |   | 22d. ADDRESS<br><b>3629 Liberty Rd</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>April 13, 1968</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Peter's Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Hampstead Baltimore Co. Md.</b>               |
| 24. FUNERAL DIRECTOR<br><b>Tipton - Eline Funeral Home</b>   |   | 25. REC'D BY REGISTRAR<br><b>APR 15 1968</b>  |   |
| ADDRESS<br><b>Hampstead, Md.</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |

10226

REPUBLIC OF BEAR

82228

[Faint, mostly illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |   |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |
| 1. DECEASED-NAME (Type or print) <b>NORMAN L. HOFFHEISER</b>   |  |  |  |  | 2a. DATE OF DEATH <b>APRIL 21 1968</b>   |  |  | 2b. HOUR <b>6:54AM</b>                                  |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH <b>APRIL 21, 1901</b>   |  | 6. AGE (In years lost, birthday) <b>67 YRS.</b>  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country) <b>STILTZ, MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>TOWSON BALTIMORE 4, MD.</b>  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>TOWSON, MD.</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSPITAL</b>                                |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>G &amp; E LINE MAN</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>BALTIMORE</b>   |  | 13b. COUNTY <b>MD</b>  |  | 13c. CITY OR TOWN <b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>1335 GITTINGS AVE. #12</b>    |  |
| 14. FATHER'S NAME First Middle Last <b>ALBERT HOFFHEISER</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>ANNIE BAICER</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO. <b>212-05-6005</b>  |  | 17. INFORMANT Address <b>MRS. HOFFHEISER</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>410.9</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarction Acute</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>4 hrs.</b>                                 |  |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/1</b> , 19 <b>66</b> , to <b>4/21</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Ruben Sebastian, M.D.</b>  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED <b>4/21/68</b>  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>RUBEN S. SEBASTIAN, M.D.</b>   |  | 22e. ADDRESS <b>2314 E. JOHNS RD. BALTO</b>  |  | <b>#34</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE <b>4-22-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Bohemian National Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>                     |  |   |  |
| 24. FUNERAL DIRECTOR <b>John C. Miller Inc-6415 Belair Rd.-21206</b>   |  |  |  | 25a. REC'D BY REGISTRAR <b>APR 24 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |   |  |

10-22-50

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

05255

05259

|   |                         |  |  |   |  |
|---|-------------------------|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>First Middle Last</b><br><b>EDWARD DORSEY HOFFMAN</b>  |                         |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>April 26, 1968</b> |   | 2b. HOUR<br><b>3:50AM</b>                    |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>March 3, 1894</b>   |  | 6. AGE (In years lost birthday)<br><b>74</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. COUNTY OF DEATH<br><b>Baltimore</b>  |                         | 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b>  |  |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Butcher</b>   |                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Meat Packing</b>   |  | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |
| 13b. COUNTY<br><b>Baltimore</b>   |                         | 13c. CITY OR TOWN<br><b>Essex</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 13e. STREET AND NUMBER<br><b>468 Barrison Pt. Rd. 21221</b>   |                         | 14. FATHER'S NAME<br>First Middle Last<br><b>Edward D. Hoffman</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Anna Miller</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW1</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>213 03 9210</b>   |  | 17. INFORMANT<br>Address<br><b>Anna Hoffman Same</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                         |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4201</b>  |                         |  |  |   |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                         | 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner) |  |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |                         | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 18, 1968</b> , to <b>April 26 19 68</b> , that (I) (we) last saw the deceased alive on <b>April 26, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                         |  |  |   |  |
| 22b. SIGNATURE<br><i>E. Montelibano</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |                         |  |  | 22c. DATE SIGNED<br><b>April 26, 1968</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>E. Montelibano, M.D.</b>   |                         |  |  | 22e. ADDRESS<br><b>7620 York Rd. Towson, Maryland 21204</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>4/29/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Co., Md.</b>  |                         | 24. FUNERAL DIRECTOR<br><i>Bruzdinski</i> ADDRESS<br><b>Bruzdinski Funeral Home 1407 Eastern Ave.</b>  |  |   |  |
| 25a. REC'D BY REGISTRAR<br>DATE <b>APR 29 1968</b>  |                         | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |   |  |

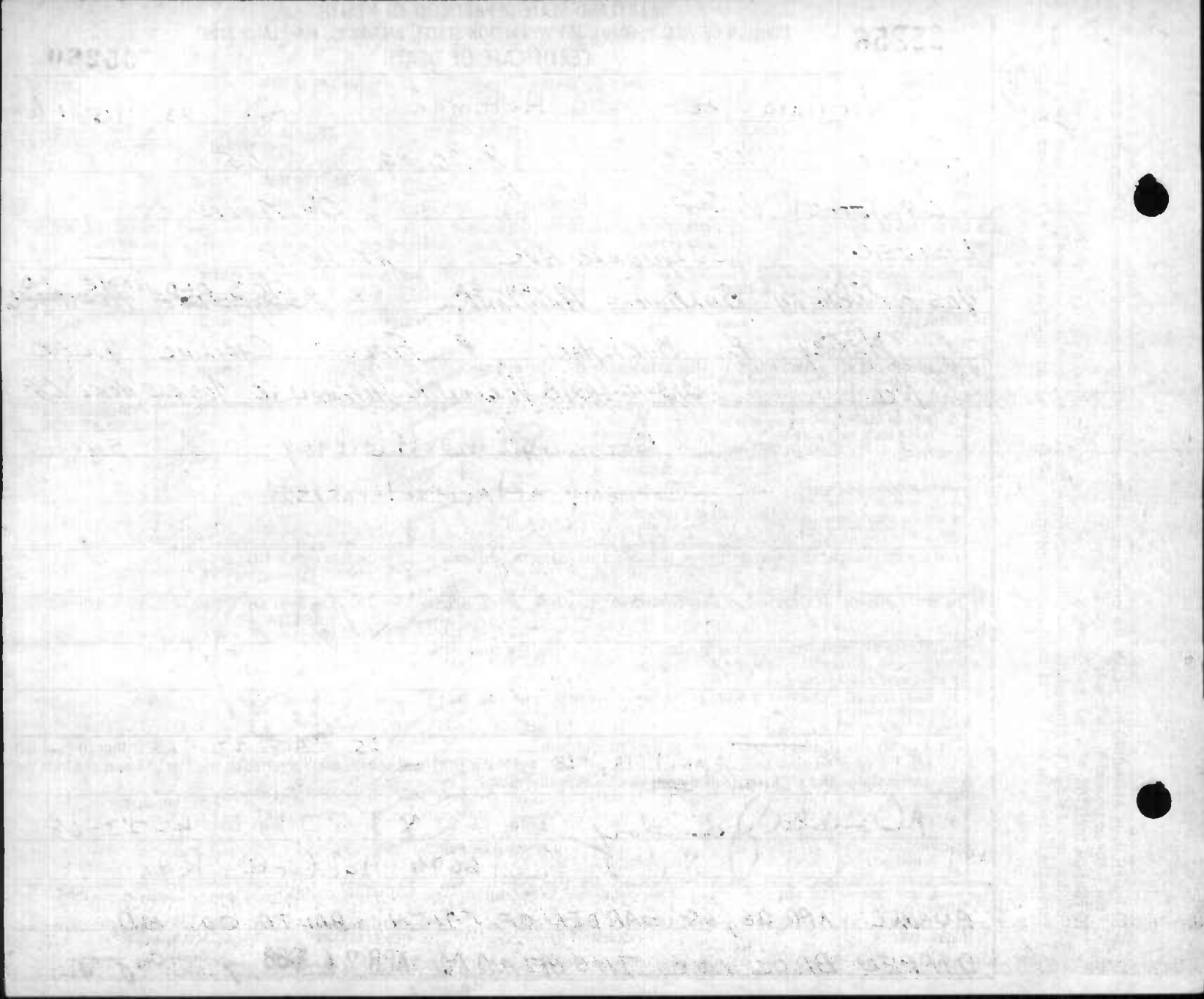
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VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |   |  |  |  |  |   |   |  |
|---|--|--|---|---|--|--|--|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |   |  |  |  |  |   |   |  |
| CERTIFICATE OF DEATH  |  |  |   |   |  |  |  |  |   |   |  |
| 1. DECEASED-NAME (Type or print) <u>Virginia A. Hoffman</u>   |  |  |   |   |  | 2a. DATE OF DEATH<br>Month <u>Apr.</u> Day <u>23</u> Year <u>1968</u>                                  |  |  | 2b. HOUR <u>1 A.</u> M <u>M</u>             |   |  |
| 3. SEX <u>FEMALE</u>  |  | 4. RACE <u>White</u>   |   | 5. DATE OF BIRTH <u>8-26-02</u>   |  | 6. AGE (In years lost birthday) <u>65</u> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <u>  </u> DAYS <u>  </u>   |   | IF UNDER 24 HRS.<br>HOURS <u>  </u> MIN <u>  </u>           |  |
| 7a. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>                                    |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <u>BALTIMORE</u>  |  |  | Md.   |   |  |
| 10. CITY OR TOWN OF DEATH <u>LINCOLN</u>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>334 WINDALE AVE</u> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>AT-HOME</u> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>  </u> |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) STATE <u>MARYLAND</u>  |  |  | 13b. COUNTY <u>BALTIMORE</u>  |   |  | 13c. CITY OR TOWN <u>OVERLEA</u>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER <u>334 WINDALE RD.</u>               |  |
| 14. FATHER'S NAME First <u>HENRY</u> Middle <u>F.</u> Last <u>BUCKHART</u>  |  |  | 15. MOTHER'S MAIDEN NAME First <u>FRANCES</u> Middle <u>CAROLINE</u> Last <u>TIGER</u>              |   |  |  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u>  |  |  | 16b. SOCIAL SECURITY NO. <u>212-10-60390</u>  |   |  | 17. INFORMANT Address <u>VERNON K. HOFFMAN SR 703 OLD HOME RD.</u>                                     |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u><br><u>4129</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>  </u>  |  |  |   |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><u>4201</u>   |  |  |   |   |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>19</u>            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |   |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>65</u> , to <u>Apr. 23</u> , 19 <u>68</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>April 19</u> , 19 <u>68</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) (did) ( <u>did not</u> ) view the body after death. |  |  |   |   |  |  |  |  |   |   |  |
| 22b. SIGNATURE <u>Donald Jandorf</u> DEGREE <u>  </u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |   |   |  |  |  | 22c. DATE SIGNED <u>4-23-68</u>  |   |   |  |
| 22d. PHYSICIAN'S NAME (Type) <u>  </u>  |  |  |   |   |  |  |  | 22e. ADDRESS <u>6077 Harford Rd.</u>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 23b. DATE <u>APR 26, 68</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY <u>GARDEN OF FAITH</u>   |  | 23d. LOCATION (City or Town) (County) (State) <u>BALTO. CO. MD</u>                                     |  |  |   |   |  |
| 24. FUNERAL DIRECTOR <u>DIPPEL BROS INC</u>   |  |  |   | ADDRESS <u>7110 BELAIR RD</u>   |  | 25a. REC'D BY REGISTRAR <u>  </u>  |  | 25b. REGISTRAR'S SIGNATURE <u>  </u>   |   |   |  |
| DATE <u>APR 24 1968</u>   |  |  |   |   |  |  |  |  |   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05257

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05261

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>ALMA REGINA HUBBARD</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>20</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>2:45 PM</b>   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br><b>4-29-86</b>  |  | 6. AGE (In years last birthday)<br><b>81</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>BALTO. MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY Md.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>G.B.M.C.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>XXXX</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>Lutherville</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>845 Kellogg Rd.</b>  |  |   |  |   |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Gustave DOLPHUS KIMMETT</b>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Margaret Stauffer</b> |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>UNKNOWN</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>Not known</b>  |  | 17. INFORMANT Address<br><b>Mrs. Alma R. Haddaway, 845 Kellogg Road</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardio respiratory failure</b><br><b>431.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>cerebral Hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>331X</b> |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                               |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                    |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-20-1968</b> , to <b>4-20-1968</b> , that (I) (we) lost saw the deceased alive on <b>2:45 pm 4-20-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>E. Satalman</b>  |  |   |  | 22c. DATE SIGNED<br><b>4-20-68</b>  |  | 22d. PHYSICIAN'S NAME (Type)   |  |
| 22e. ADDRESS  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4-23-1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cambridge Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cambridge, Maryland</b>                  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 23 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James Judge</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |  |        |  |                   |  |          |  |
|--|--|--|--------|--|-------------------|--|----------|--|
| 1. DECEASED-NAME<br>(Type or print)  |  | First  | Middle | Last   | 2a. DATE OF DEATH |  | 2b. HOUR |  |
| Edna Livina Hulsey   |  |  |        |  | Month             | Day  | Year     | A. 35 M.                                     |
| 3. SEX   |  | 4. RACE  |        | 5. DATE OF BIRTH   |                   | 6. AGE (In years last birthday)  |          | 7. IF UNDER 1 YEAR                           |
| Female   |  | White  |        | Mar. 20, 1882  |                   | 86 YRS.  |          | MONTHS DAYS HOURS MIN.                       |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                   | 9. COUNTY OF DEATH   |          |  |
| Pa.  |  | U.S.A.   |        |  |                   | Baltimore Md.  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |                   | 12b. KIND OF BUSINESS OR INDUSTRY  |          |  |
| Catonsville  |  | Caton Ridge Nursing H  |        | R. Nurse   |                   | Nursing  |          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |        | 13c. CITY OR TOWN  |                   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          | 13e. STREET AND NUMBER                       |
| Md.  |  |  |        | Baltimore  |                   |  |          | Park Heights Ave.                            |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |        |  |                   |  |          |  |
| First Middle Last  |  | First Middle Last  |        |  |                   |  |          |  |
| Frank Ausburn  |  | Mary Swanger   |        |  |                   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT Address  |                   |  |          |  |
| no   |  | 214-20-6462  |        | Margaret H. Weisensel 41 N. Prospect Ave   |                   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>485X</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____      |  |  |        |  |                   |  |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Generalized Arteriosclerosis - urethral stricture</u>   |  |  |        |  |                   |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                   |  |          |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                   |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-4-</u> , 19 <u>66</u> , to <u>4-16-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-16-</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |        |  |                   |  |          |  |
| 22b. SIGNATURE   |  | DEGREE   |        | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |                   | 22c. DATE SIGNED   |          |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |        |  |                   |  |          |  |
| CESAR VALLE CAVERO   |  | 2829 Liberty Rd  |        |  |                   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |                   | 23d. LOCATION (City or Town) (County) (State)  |          |  |
| Burial   |  | 4-17-1968  |        | Loudon Park  |                   | Baltimore Md.  |          |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |        | 25a. REC'D BY REGISTRAR  |                   | 25b. REGISTRAR'S SIGNATURE   |          |  |
| G. Howard Strong   |  | 3207 W. North Ave.   |        | DATE APR 18 1968   |                   | Richard J. Judge   |          |  |

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White 1915

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Edmond H. 1915

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |                              |  |   |   |                                     |  |   |
|---|------------------------------|--|---|---|-------------------------------------|--|---|
| 1. DECEASED-NAME<br>(Type or print)   |                              | First  | Middle  | Last  | 2a. DATE OF DEATH<br>Month Day Year |  | 2b. HOUR                                  |
| Hilda   |                              |  |   | HURLEY  | April 27 1968                       |  | 2:45 PM                                   |
| 3. SEX  | 4. RACE                      |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| Female  | White                        |  | October 15, 1907  |   | 60 YRS.                             |  |   |
| 7a. BIRTHPLACE (State or foreign country)   | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH                  |  | Md.                                       |
| Virginia  | US                           |  | Baltimore   |   |                                     |  |   |
| 10. CITY OR TOWN OF DEATH   |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)       |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                     | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| Catonsville-21228.  |                              | Spring Grove State Hospital  |   | housewife   |                                     |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN   |                                     | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 1517 W. Lombard Str. Baltimore City   |                              | Balto.   |   | 1517 W. Lombard Street  |                                     |  |   |
| 14. FATHER'S NAME   |                              | 15. MOTHER'S MAIDEN NAME   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)   |                                     | 16b. SOCIAL SECURITY NO.   |   |
| ? deceased  |                              | ? deceased   |   | no  |                                     | no   |   |
| 17. INFORMANT   |                              | Address  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Uremia, Hypertension, Chronic Alcoholism.</u> |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |
| 19a. DATE OF OPERATION  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |
| none  |                              | none   |   |   |                                     |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                         |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                     |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |                              | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |                                     |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 26</u> , 19 <u>67</u> , to <u>April 27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>April 27</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                              | 22b. SIGNATURE<br><u>B. Imre Kopits</u><br>DEGREE                                  |   | 22c. DATE SIGNED<br><u>April 27, 1968</u>   |                                     |  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Dr Imre Kopits, M.D.</u>   |                              | 22e. ADDRESS<br><u>Spring Grove State Hospital</u>                                 |   |   |                                     |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                              | 23b. DATE<br><u>April 30/68</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Park</u>   |                                     | 23d. LOCATION (City or Town) (County) (State)<br><u>Dorchester Mem. Cambridge Md.</u>        |   |
| 24. FUNERAL DIRECTOR<br><u>Philip Herwig Sons</u>   |                              | 25a. REC'D BY REGISTRAR<br><u>APR 30 1968</u>                                      |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |                                     |  |   |
| Philip Herwig Sons 2024 Orleans St. 31  |                              |  |   |   |                                     |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/66

| <div style="display: flex; justify-content: space-between;"> <span>05261</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>05265</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>   |  |  |  |   |                             |   |  |  |   |       |  |  |
|--|--|--|--|---|-----------------------------|---|--|--|---|-------|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last<br>(Donner) Anna (PAISY) (EVANOSKA) Ivanauskas  |  |  |  |   |                             | 2a. DATE OF DEATH<br>Month Day Year<br>April 9, 1968  |  |  | 2b. HOUR a. 9:15 M                            |       |  |  |
| 3. SEX<br>female   |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>Dec. 1894   |                             |   | 6. AGE (In years last birthday)<br>73 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                |       | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Lithuania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Lithuania                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |   |       |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>SPRING GROVE STATE HOSP. |   |                             | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>housewife                            |  |  | 12b. KIND OF BUSINESS OR INDUSTRY             |       |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  |  | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>Balto. |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>807 Woodward Street |       |  |  |
| 14. FATHER'S NAME First Middle Last<br>Stanley Kanchis   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Marsella Milan  |                             |   |  |  |   |       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |  |  | 16b. SOCIAL SECURITY NO.<br>2/5-01-0581   |                             | 17. INFORMANT Address<br>Records: SPRING GROVE STATE HOSPITAL   |  |  |   |       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Infarction of heart</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Generalized arteriosclerosis</u>  |  |  |  |   |                             |   |  |  |   |       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><u>4201</u>  |  |  |  |   |                             |   |  |  |   |       |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |       |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                             |   |  |  |   |       |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |                             | City or Town  |  | County   |   | State |  |  |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from <u>March 6, 1954</u> , to <u>April 9, 1968</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>April 9, 1968</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death. |  |  |  |   |                             |   |  |  |   |       |  |  |
| 22b. SIGNATURE<br><u>Vicente M. Ruano M.D.</u> DEGREE  |  |  |  |   |                             | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br>4-9-68   |   |       |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Vicente Ruano, M.D.  |  |  |  |   |                             | 22e. ADDRESS<br>SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228  |  |  |   |       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>4-11-68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Most Holy Redeemer Cem  |                             |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.                      |  |   |       |  |  |
| 24. FUNERAL DIRECTOR<br>Thomas J. Kenny Inc 1600 Hollins St  |  |  |  |   |                             | 25a. REC'D BY REGISTRAR<br>DATE APR 11 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                   |   |       |  |  |

MEDICAL CERTIFICATION

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VR:ATS (M)  
30M REV. 11/68

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05262

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|   |  |   |  |   |  |   |   |  |   |  |   |  |
|---|--|---|--|---|--|---|---|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br><b>Robert</b>  |  | Middle<br><b>Lester</b>   |  | Last<br><b>Jenkins</b>  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>April 1st, 1968</b>                    |   |  | 2b. HOUR<br>M<br><b>1</b>                             |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br><b>March 13, 1901</b>   |  |   | 6. AGE (In years last birthday)<br><b>67</b> YRS. |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>1</b> <b>1st</b> |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>1</b> <b>1st</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Wash. D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SPRING GROVE STATE HOSP.</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>laborer</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                     |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Pr. Geo.</b>  |  | 13c. CITY OR TOWN<br><b>Wash. D.C.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |   | 13e. STREET AND NUMBER<br><b>7007 Walker Mill Road</b>                           |   |  |   |  |
| 14. FATHER'S NAME First Middle Last<br><b>Randall Jenkins</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Eva m. Lynch</b>   |  |   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>579-09-3912</b>  |  | 17. INFORMANT Address<br><b>Records: SPRING GROVE STATE HOSPITAL</b>  |  |   |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic, Cardiovascular Ht. Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis, Generalized, senile.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 years.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days.</b> |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221</b>   |  |   |  |   |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?             |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |   |  |   |  |
| 22a. I certify that <del>(I)</del> (this hospital) attended the deceased from <b>Oct. 19</b> , 19 <b>67</b> , to <b>April 1</b> , 19 <b>68</b> , that <del>(I)</del> (we) last saw the deceased alive on <b>April 1</b> , 19 <b>68</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did not) view the body after death.             |  |   |  |   |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Anthony J. Young, M.D.</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |   |  |   |  |   |   | 22c. DATE SIGNED<br><b>4-1-68</b>  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Anthony J. Young, M.D.</b>   |  |   |  |   |  |   |   | 22e. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b> |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>April 4, 68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Epiphany Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Forestville, Maryland</b>                             |   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>Simmons Bros.</i> ADDRESS<br><b>Simmons Bros. 1661-Gd. Hope Rd. SE Wash., D.C.</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>DATE APR 3 - 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |   |  |   |  |   |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)  
30M REV. 1/68

| 05263  |  |  |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  | 05267  |  |                               |  |
|--|--|--|--|---|--|---|--|--|--|-------------------------------|--|
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>Julia G. Jennings</b>   |  |  |  | 2a. DATE OF DEATH Month Day Year<br><b>4 15 68</b>  |  |   |  | 2b. HOUR<br><b>11:30 A</b>   |  |                               |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br><b>Oct. 23, 1887</b>  |  | 6. AGE (In years lost birthday) YRS. MONTHS DAYS<br><b>80</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |  | IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Sherrillsburg, N. S. C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Balto.</b>   |  |  |  |                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Liberty Rd; Randallstown, Md.</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>                     |  |                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto</b>  |  | 13c. CITY OR TOWN<br><b>Balto 21234</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  | 13e. STREET AND NUMBER<br><b>1100 Rowan Court</b>                    |  |                               |  |
| 14. FATHER'S NAME First Middle Last<br><b>Thomas M. Corey</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Lula Showalter</b>   |  |   |  |  |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-45-3004</b>   |  | 17. INFORMANT<br><b>Lucy Graham</b>   |  |   |  | Address<br><b>1150 Rowan Court Balto 21234</b>                       |  |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b><br>4109<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>C. V. A.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>A-S-C. V.D.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 HRS.</b><br><b>2 day</b><br><b>10 yrs.</b> |  |  |  |   |  |   |  |  |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>4201</b>   |  |  |  |   |  |   |  |  |  |                               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19<br><b>4-15 1968</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |                               |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>FEB 1968, to APR. 15, 1968</b>   |  |   |  |  |  |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEB 1968</b> , to <b>APR. 15, 1968</b> , that (I) (we) last saw the deceased alive on <b>4-15 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |                               |  |
| 22b. SIGNATURE<br><b>R. V. Houck, Jr.</b>  |  |  |  | M.D. DEGREE   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4-15-68</b>                                   |  |                               |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>R. V. Houck, Jr.; M. D.</b>   |  |  |  | 22e. ADDRESS<br><b>Liberty Rd; Eldersburg, Md.</b>  |  |   |  |  |  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4-18-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maple Hill</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Bluefield, Va.</b>  |  |  |  |                               |  |
| 24. FUNERAL DIRECTOR<br><b>Graham Funeral Home</b>   |  |  |  | ADDRESS<br><b>Bluefield, Va.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |  |                               |  |
| DATE<br><b>APR 19 1968</b>   |  |  |  |   |  |   |  |  |  |                               |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05264

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05268

|  |                  |  |   |  |  |   |  |  |  |  |
|--|------------------|--|---|--|--|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <i>William Fell Johnson</i>  |                  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>4</i> Day <i>13</i> Year <i>68</i> |  |  | 2b. HOUR <i>5:00</i> P.M.   |  |  |  |  |
| 3. SEX <i>M</i>  | 4. RACE <i>W</i> | 5. DATE OF BIRTH <i>8-18-1884</i>          | 6. AGE (in years last birthday) <i>83</i> YRS.  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  | IF UNDER 24 HRS.<br>HOURS<br>MIN.  | 2c. DATE PRONOUNCED DEAD<br>Month <i>4</i> Day <i>13</i> Year <i>68</i>                               |  |  | 2d. HOUR <i>5:35</i> P.M.                    |  |
| 7a. BIRTHPLACE (State or foreign country) <i>BALTO, MD</i>   |                  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <i>Baltimore Co.</i> Md.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <i>TOWSON</i>  |                  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Joseph Hosp.</i>    |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>LAWYER</i> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>LAW</i> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>  |                  |  | 13b. COUNTY <i>BALTO.</i>   |  | 13c. CITY OR TOWN <i>BROOKLANVILLE</i>   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  | 13e. STREET AND NUMBER   |  |  |
| 14. FATHER'S NAME First <i>ROBERT</i> Middle <i>W.</i> Last <i>JOHNSON</i>   |                  |  | 15. MOTHER'S MAIDEN NAME First <i>JULIA</i> Middle <i>W. H.</i> Last <i>BROCK</i>                       |  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>  |                  |  | 16b. SOCIAL SECURITY NO. <i>213-48-5408</i>   |  | 17. INFORMANT ADDRESS <i>DR. ROBERT W. JOHNSON BALTO, MD</i>   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>8129</i> IMMEDIATE CAUSE (a) <i>Multiple Injuries</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |                  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>2164</i>   |                  |  |   |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |  | 21b. TIME OF INJURY Month, Day, Year <i>5:00 P.M. 4.13 19 68</i>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Passed stop sign struck other vehicle</i> |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>street</i>              |  | 21f. LOCATION Street or R.F.D. No. <i>Manor Road</i>   |   | City or Town <i>Jarrettsville</i>  |  | County <i>BALTO</i> State <i>MD</i>          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |  |   |  |  |   |  |  |  |  |
| ACTUAL SIGNATURE <i>Werner H. Spitz</i>  |                  |  | EXAMINER'S NAME (Type) <i>Wetner H. Spitz</i>   |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  | 22b. DATE SIGNED <i>4.14.68</i>              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  |                  |  | 23b. DATE <i>4-16-68</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>St. Thomas'</i>  |   |  | 23d. LOCATION (City or Town) (County) (State) <i>Garrison Forest Md.</i> |  |  |
| 24. FUNERAL DIRECTOR ADDRESS <i>H.W.Jenkins &amp; Sons Co. 4905 York Rd.</i>   |                  |  |   |  | 25a. REC'D BY REGISTRAR <i>APR 16 1968</i>   |   | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>                                  |  |  |  |

MEDICAL CERTIFICATION

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                     |  |   |   |  |
|---|---------------------|--|---|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>EFFIE</b> First <b>M.</b> Middle <b>JONES</b> Last   |                     |  | 2a. DATE KNOWN OF DEATH<br>Month <b>4</b> Day <b>1</b> Year <b>1968</b> |   | 2b. HOUR<br><b>2 P</b>   |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br><b>8-12-1891</b>   | 6. AGE (In years last birthday)<br><b>77</b> YRS.                       | 2c. DATE PRONOUNCED DEAD<br>Month <b>4</b> Day <b>1</b> Year <b>1968</b>  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Ind.</b>  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Int. Wilson</b>   |                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Int. Wilson</b>       |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Ind.</b>   |                     | 13b. COUNTY<br><b>Dorchester Cambridge</b>   |   | 13c. STREET AND NUMBER<br><b>406 Light St.</b>  |  |
| 14. FATHER'S NAME<br><b>Samuel M. Meredith</b>  |                     |  | 15. MOTHER'S MAIDEN NAME<br><b>Angie N. Cannon</b>                      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b>   |                     | 16b. SOCIAL SECURITY NO.<br><b>214-07-9197</b>   |   | 17. INFORMANT<br><b>Int. Wilson Records - Int. Wilson Ind.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Trans Cervical Fracture of RT Femur 1 mo.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Far Advanced Pulmonary The.</b>  |                     |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 wks</b><br><b>1 1/2 yrs</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>9037 Arterio Sclerotic Heart Disease</b>   |                     |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>Mar 18 '68</b>   |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>Fractured Femur.</b>                             |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/><br>CAUSE OF DEATH  |                     | 21b. TIME OF INJURY Month, Day, Year<br><b>12-15-68</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Fell to floor going from bed to bath room.</b>                        |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |                     | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Int. Wilson Hosp.</b> |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>Int. Wilson Bath. Ind.</b>   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                     |  |   |   |  |
| ACTUAL SIGNATURE<br><b>D.D. Caples</b>  |                     | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | 22b. DATE SIGNED<br><b>4/1/68</b>   |  |
| EXAMINER'S NAME (Type)<br><b>D.D. CAPLES, M.D.</b>  |                     | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   | ADDRESS (Street, City, Town, or County)<br><b>6 N. HANOVER Rd. - REISTERSTOWN, Md. 21136</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                     | 23b. DATE<br><b>Apr. 3, 1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dorchester Memorial Park</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>LeCompte Funeral Service, Cambridge, Maryland</b>  |                     | ADDRESS<br><b>Cambridge, Maryland</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cambridge, Maryland</b>   |  |
| 25a. REC'D BY REGISTRAR<br><b>4 - 1968</b>  |                     | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |   |  |

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*[Faint handwritten notes, possibly bleed-through from the reverse side.]*

Accepted: 11 October 2004

© 1987 by J. M. Jones

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B. S. Johnson

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### Analyses conducted

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1003. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |                  |  |                 |      |   |     |                                 |  |  |  |
|--|---------|------------------|--|-----------------|------|---|-----|---------------------------------|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |                  |  |                 |      |   |     |                                 |  |  |  |
| 1. DECEASED-NAME<br>(Type or Print)  |         |                  | First Middle Last  |                 |      | 2a. DATE KNOWN OF DEATH   |     |                                 | 2b. HOUR   |  |  |
| SHERRILL   |         |                  | LLOYD  |                 |      | JONES   |     |                                 | <input checked="" type="checkbox"/> Month Day Year<br><input type="checkbox"/> ESTI- MATED <input type="checkbox"/> April 6, 1968:50 M |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR |      | IF UNDER 24 HRS.  |     | 2c. DATE PRONOUNCED DEAD        |  | 2d. HOUR                                     |  |
| Male   | White   |                  | 54 YRS.  | MONTHS          | DAYS | HOURS   | MIN | Month Day Year<br>April 6, 1968 |  | 6:50 PM                                      |  |
| 7a. BIRTHPLACE (State or foreign country)  |         |                  | 7b. CITIZEN OF WHAT COUNTRY?   |                 |      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |     |                                 | 9. COUNTY OF DEATH   |  |  |
|  |         |                  |  |                 |      |   |     |                                 | BALTIMORE Md.  |  |  |
| 10. CITY OR TOWN OF DEATH  |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                 |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |     |                                 | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| Cockeysville / Towson  |         |                  | St. Joseph Hosp.   |                 |      |   |     |                                 |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                  | 13b. COUNTY  |                 |      | 13c. CITY OR TOWN   |     |                                 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |
|  |         |                  |  |                 |      |   |     |                                 | (Unknown)  |  |  |
| 14. FATHER'S NAME  |         |                  | 15. MOTHER'S MAIDEN NAME   |                 |      |   |     |                                 |  |  |  |
| First Middle Last  |         |                  | First Middle Last  |                 |      |   |     |                                 |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                  | 16b. SOCIAL SECURITY NO.   |                 |      | 17. INFORMANT   |     |                                 | ADDRESS  |  |  |
|  |         |                  |  |                 |      |   |     |                                 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                  |  |                 |      |   |     |                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:   |         |                  |  |                 |      |   |     |                                 |  |  |  |
| IMMEDIATE CAUSE (a) Multiple injuries  |         |                  |  |                 |      |   |     |                                 |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                  |  |                 |      |   |     |                                 |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |         |                  |  |                 |      |   |     |                                 |  |  |  |
| (b)  |         |                  |  |                 |      |   |     |                                 |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                  |  |                 |      |   |     |                                 |  |  |  |
| (c)  |         |                  |  |                 |      |   |     |                                 |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |                  |  |                 |      |   |     |                                 |  |  |  |
| 802x   |         |                  |  |                 |      |   |     |                                 |  |  |  |
| 19a. DATE OF OPERATION   |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |                 |      | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |     |                                 |  |  |  |
|  |         |                  |  |                 |      |   |     |                                 |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                  | 21b. TIME OF INJURY Month, Day, Year   |                 |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |     |                                 |  |  |  |
|  |         |                  | 4:50 P.M. 4-6 19 68  |                 |      | Sitting on R.R. tracks  |     |                                 |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                 |      | 21f. LOCATION Street or R.F.D. No. City or Town County State  |     |                                 |  |  |  |
|  |         |                  | R.R. tracks  |                 |      | R.R. marker N-152 W. end of Cockeysville Md. Baltimore Md.  |     |                                 |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                  |  |                 |      |   |     |                                 |  |  |  |
| ACTUAL SIGNATURE   |         |                  | Charles S. Springate, M.D.   |                 |      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |     |                                 | 22b. DATE SIGNED   |  |  |
| EXAMINER'S NAME (Type)   |         |                  |  |                 |      | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |     |                                 | April 7, 1968  |  |  |
|  |         |                  |  |                 |      | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |     |                                 | ADDRESS (Street, city, town, or county)  |  |  |
|  |         |                  |  |                 |      |   |     |                                 |  |  |  |
| 23a. BURIAL (CREMATION REMOVAL) (Specify)  |         |                  | 23b. DATE  |                 |      | 23c. NAME OF CEMETERY OR CREMATORY  |     |                                 | 23d. LOCATION (City or Town) (County) (State)  |  |  |
|  |         |                  | 4-30-68  |                 |      | C of Md Med School  |     |                                 | Baltimore Md.  |  |  |
| 24. FUNERAL DIRECTOR   |         |                  |  |                 |      | 25a. REC'D BY REGISTRAR   |     |                                 | 25b. REGISTRAR'S SIGNATURE   |  |  |
|  |         |                  |  |                 |      | MAY 2 1968  |     |                                 | Charles Judge  |  |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05271

|  |  |  |  |   |  |   |  |  |  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>ELIZABETH</b>   |  | First  |  | Middle  |  | Last  |  | 2a. DATE KNOWN <input type="checkbox"/> Month Day Year<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> April 3, 1968 |  | 2b. HOUR <sup>a</sup><br>10:15 <sup>M</sup>                        |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>Oct 22 1919</b>  |  | 6. AGE (In years<br>last birthday)<br><b>48</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>April 3, 1968</b> |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>West Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>St. Joseph Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>School Nurse</b> |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Balto County</b>  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Townson</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  | 13e. STREET AND NUMBER<br><b>8436 Pleasant Plains Road</b>   |  |  |  |  |
| 14. FATHER'S NAME<br><b>Owen Milton Hook</b>   |  |  |  | First   |  | Middle  |  | Last   |  | 15. MOTHER'S MAIDEN NAME<br><b>Bertie Jane McLaughlin</b>          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>World War 2 236-24-4364</b>        |  | 17. INFORMANT<br><b>Stephen Kaminitzky</b> ADDRESS<br><b>8436 Pleasant Plains Rd.</b>   |  |   |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intracerebral Hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. <b>4309</b><br>(b) <b>Rupture of Berry Aneurysm</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                    |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><b>330X</b>   |  |  |  |   |  |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                      |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)                            |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County   |  | State  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |   |  |   |  |  |  |  |  |  |
| ACTUAL<br>SIGNATURE<br><b>Ronald N. Kornblum</b>   |  | EXAMINER'S<br>NAME (Type)<br><b>Ronald N. Kornblum, M.D.</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  | 22b. DATE SIGNED<br><b>4-3-68</b>                                  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/7/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Trinity Cem.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Elkridge, Maryland</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 9 - 1968</b>  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Dippel Bro's Inc. 1800 E. Lombard St. 21231</b>   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |  |  |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

|   |         |  |           |  |   |   |                                   |                                   |                          |  |
|---|---------|--|-----------|--|---|---|-----------------------------------|-----------------------------------|--------------------------|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First  | Middle    | Last   | 2a. DATE KNOWN OF DEATH   |   | Month                             | Day                               | Year                     | 2b. HOUR                                     |
| Paul  |         | Peter  | Katchmere |  | MATED   |   | April                             | 25                                | 1968                     | 10A M  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |           | 6. AGE (in years lost birthday)  | IF UNDER 1 YEAR   |   | IF UNDER 24 HRS                   |                                   | 2c. DATE PRONOUNCED DEAD |  |
| Male  | White   | 3/2/02   |           | 66 YRS.  | MONTHS  |   | DAYS                              |                                   | Month Day Year           |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |                                   | 12b. KIND OF BUSINESS OR INDUSTRY |                          |  |
| Poland  |         | U. S. A.   |           |  |   | Baltimore   |                                   | Owens Co.                         |                          |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) |           |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY |                                   |                          |  |
| Dundalk   |         | 2625 Yorkway   |           |  | Carpenter   |   |                                   |                                   |                          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |           | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?  |                                   | 13e. STREET AND NUMBER            |                          |  |
| Maryland  |         | Baltimore  |           | Dundalk  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 2625 Yorkway                      |                          |  |
| 14. FATHER'S NAME   |         | First  | Middle    | Last   | 15. MOTHER'S MAIDEN NAME  |   | First                             | Middle                            | Last                     |  |
| John  |         | J.   | Katchmere |  | Elizabeth   |   |                                   | Subks                             |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         | 16b. SOCIAL SECURITY NO.   |           | 17. INFORMANT (Friend)   |   | ADDRESS   |                                   |                                   |                          |  |
| No  |         | 180-07-0393  |           | Mrs. Anna E. McGee, 2 Admiral Blvd.  |   | Dundalk, Md.  |                                   |                                   |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>A-S-C-V-Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>4129</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>4221</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |         |  |           |  |   |   |                                   |                                   |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |         |  |           |  |   |   |                                   |                                   |                          |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |           |  |   | 20. AUTOPSY?  |                                   |                                   |                          |  |
|   |         |  |           |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |                                   |                          |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY Month, Day, Year   |           | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |                                   |                                   |                          |  |
|   |         | P.M. 19  |           |  |   |   |                                   |                                   |                          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |           | 21f. LOCATION Street or R.F.D. No.   |   | City or Town  |                                   | County                            |                          | State  |
|   |         |  |           |  |   |   |                                   |                                   |                          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |  |           |  |   |   |                                   |                                   |                          |  |
| ACTUAL SIGNATURE  |         | M.D.   |           |  |   | CHIEF MEDICAL EXAMINER  |                                   |                                   |                          |  |
| EXAMINER'S NAME (Type)  |         | M.D.   |           |  |   | 8600 Mornington Road  |                                   |                                   |                          |  |
| Melvin B. Davis   |         |  |           |  |   | 22b. DATE SIGNED  |                                   |                                   |                          |  |
|   |         |  |           |  |   | Dundalk 4/26/68   |                                   |                                   |                          |  |
|   |         |  |           |  |   | ADDRESS (Street, city, town, or county) Md. 21222                   |                                   |                                   |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |           | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town)  |                                   | (County)                          |                          | (State)                                      |
| Burial  |         | 4/29/68  |           | Oak Lawn Cemetery  |   | Baltimore, Md.  |                                   |                                   |                          |  |
| 24. FUNERAL DIRECTOR  |         |  |           |  |   | 25a. REC'D BY REGISTRAR   |                                   | 25b. REGISTRAR'S SIGNATURE        |                          |  |
| John J. Duda, 7922 Wise Ave. Dundalk, Md.   |         |  |           |  |   | DATE APR 30 1968  |                                   | Charles J. J...                   |                          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 05269   |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |   |   |  | 05273   |  |
| CERTIFICATE OF DEATH  |  |  |   |   |  |   |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>LILLIE RACHEL KATZ  |  |  | 2a. DATE OF DEATH Month Day Year<br>April 24 1968       |   |  | 2b. HOUR<br>1:13 PM   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)<br>70 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Poland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>3403 Cardinal Ct                   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Not Home   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>STATE  |  | 13b. COUNTY<br>✓ Erie  |   | 13c. CITY OR TOWN<br>Erie   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>127 E. 17th St.   |  |  |   |   |  |   |  |
| 14. FATHER'S NAME First Middle Last<br>Herman Rubin Berenson  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Roberta ? |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)  |   | 17. INFORMANT<br>Nathaniel Katz - 3403 Cardinal Court   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis</u><br>199.1<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>199.2   |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)<br>While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                       |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/14, 1968, to 4/24, 1968, that (I) (we) lost saw the deceased alive on 4/24 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br>Leonard H. Golombeck  |  |  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br>4/24/68   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>LEONARD H. GOLOMBECK  |  |  |   | 22e. ADDRESS<br>LIBERTY ROAD  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br>April 24/68   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cong. B'nai Shalom  |  | 23d. LOCATION (City or Town) (County) (State)<br>Erie, Pa.                                      |  |
| 24. FUNERAL DIRECTOR<br>Sol Levinson & Sons 6010 Reisterstown Rd  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE APR 29 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Certification  
*Robert J. M.D.*

| <div style="display: flex; justify-content: space-between;"> <span>05270</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>05274</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br/> <b>CERTIFICATE OF DEATH</b> </div>   |  |  |   |  |  |   |  |  |   |  |  |  |  |                                |                            |  |
|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--------------------------------|----------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br><b>RUTH</b>  |  |  | Middle  |  |  | Last<br><b>KATZ</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>28</b> Year <b>1968</b> |  |                                | 2b. HOUR<br><b>9 P. M.</b> |  |
| 3. SEX<br><b>F.</b>  |  |  | 4. RACE<br><b>White</b>   |  |  | 5. DATE OF BIRTH<br><b>2/9/1894</b>   |  |  | 6. AGE (In years last birthday)<br><b>74</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                          |  | IF UNDER 24 HRS.<br>HOURS MIN. |                            |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>M.D.</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore County, Md.</b>  |  |  |  |  |                                |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mount Wilson</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Wilson State Hosp.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |                                |                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>M.D.</b>   |  |  | 13b. COUNTY<br><b>Balto.</b>  |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>1727 White Oak Ave.,</b>              |  |                                |                            |  |
| 14. FATHER'S NAME First<br><b>Leonard</b>  |  |  | Middle<br><b>Bell</b>   |  |  | Last<br><b>Bell</b>   |  |  | 15. MOTHER'S MAIDEN NAME First<br><b>Delia</b>  |  |  | Middle<br><b>Bradford</b>  |  |                                | Last                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>no</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-54-4772</b>  |  |  | 17. INFORMANT<br>Address<br><b>Records, Mt. Wilson State Hospital</b>   |  |  |   |  |  |  |  |                                |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>444.2</b><br>IMMEDIATE CAUSE (a) <b>Portal Vein Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Infarction of small bowel (ileum)</b><br>(b) <b>Cor pulmonale</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Pulmonary emphysema</b><br>(c) <b>Pulmonary emphysema</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>5702 Pulmonary emphysema</b> |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                       |  |                                |                            |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b>              |  |  |  |  |                                |                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |  |                                |                            |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |  |  |                                |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/3/1968</b> , to <b>4/28/1968</b> , that (I) (we) last saw the deceased alive on <b>4/28/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |  |   |  |  |  |  |                                |                            |  |
| 22b. SIGNATURE<br><b>William Newcomer, M.D.</b>  |  |  |   |  |  |   |  |  |   |  |  | 22c. DATE SIGNED   |  |                                |                            |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William Newcomer, M.D.</b>  |  |  | 22e. ADDRESS<br><b>Mount Wilson, Maryland</b>   |  |  |   |  |  |   |  |  |  |  |                                |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>5/2/68</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cem.</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>                              |  |  |  |  |                                |                            |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. Balto. Md.</b>   |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 30 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |  |                                |                            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A154  
30M REV. 1-69

| <div style="display: flex; justify-content: space-between;"> <span>05271</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>05275</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>   |  |  |  |   |  |   |  |  |  |   |  |
|---|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Michael F. KELLEY</b>  |  |  |  | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>18</b> Year <b>1968</b>  |  |   |  | 2b. HOUR <b>11:30</b> A.   |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>August 27, 1904</b>  |  |   |  | 6. AGE (In years last birthday)<br><b>63</b> YRS.                                  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Connecticut</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. JOSEPH HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Community coordinator</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto City</b> |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                    |  | 13e. STREET AND NUMBER<br><b>4112 Mary Ave.</b>                                    |  |   |  |
| 14. FATHER'S NAME<br>First <b>John</b> Middle <b>Kelley</b> Last <b>Kelley</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Margaret</b> Middle <b>Colon</b> Last <b>Colon</b>   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>214-40-4475</b>   |  | 17. INFORMANT<br>Address <b>Evelyn M. Kelley 4112 Mary Avenue 21206</b>   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br><b>4109</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>               |  |  |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>   |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?               |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |   |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |  |   |  |
| 22a. I certify that <b>he</b> (this hospital) attended the deceased from <b>4/18/</b> , 19 <b>68</b> , to <b>4/18/</b> , 19 <b>68</b> , that <b>he</b> (we) last saw the deceased alive on <b>4/18/</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Camilo Z. Tomboc</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |  |  |   |  |   |  | 22c. DATE SIGNED<br><b>April 18, 1968</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Camilo Z. Tomboc</b>   |  |  |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4-22-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK CEMETERY</b>   |  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>3001 FEDERICK RD. MARYLAND</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>DIPPEL BROTHERS INC</b> ADDRESS <b>7110 BRAIR ROAD</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>APR 22 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |   |  |   |  |   |  |
|--|--|--|---|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |   |  |   |  |   |  |
| CERTIFICATE OF DEATH   |  |  |   |   |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>THOMAS WALTER KELLEY (Kelly)  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br>April 2 1968 |   |  | 2b. HOUR<br>9:p M   |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>November 6, 1905  |  | 6. AGE (In years<br>last birthday)<br>62 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Vienna, Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>St. Joseph Hospital |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>RETIRED SUPERVISOR  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>EMERSON DRUG CO   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>PARKVILLE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>3004 Parktowne Rd.                    |  |
| 14. FATHER'S NAME First Middle Last<br>THOMAS J. KELLEY  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>IDA MAE BRAMBLE   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>215-01-0518  |   | 17. INFORMANT Address<br>MRS. MARGARET E. KELLEY (SAME)   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) (Endotoxin Shock) Endotoxin Shock<br>2500 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>260x Diabetic Ketoacidosis   |  |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                        |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from April 1, 1968, to April 2, 1968, that (X) (we) last saw the deceased alive on April 2, 1968, and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.                           |  |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Jose Nepomuceno  |  |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |  |   |  | 22c. DATE SIGNED<br>4/2/68                                      |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Jose Nepomuceno, M.D.  |  |  |   | 22e. ADDRESS  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  | 23b. DATE<br>4-6-1968  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD CEMETERY   |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTO., Md.                                    |  |   |  |
| 24. FUNERAL DIRECTOR<br>J. Walter Conklin  |  |  |   | ADDRESS<br>5444 BELAIR RD   |  | 25a. REC'D BY REGISTRAR<br>DATE APR 8 - 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. [Signature]            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR-10 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |   |                |   |  |   |                    |
|---|--|---|----------------|---|--|---|--------------------|
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br>Baby   | Middle<br>Girl | Last<br>KENT  | 2a. DATE OF DEATH<br>Month Day Year<br>April 9, 1968 |   | 2b. HOUR<br>8:15AM |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |                | 5. DATE OF BIRTH<br>April 9, 1968   |  | 6. AGE (In years last birthday)<br>YRS. MONTHS DAYS<br>1 45                                     |                    |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore, Md.  |                    |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>ST. JOSEPH HOSPITAL |                | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                    |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |                | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                    |
| 13e. STREET AND NUMBER<br>130 Slade Ave.  |  | 14. FATHER'S NAME<br>First Middle Last<br>Victor Kent   |                | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Patricia Ann Brigandi  |  |   |                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                                   |                | 17. INFORMANT<br>Address  |  |   |                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Immaturity</u><br><u>7701</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Premature rupture of membranes</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Premature separation of placenta</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |                |   |  |   |                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>7615</u>   |  |   |                |   |  |   |                    |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                    |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |                | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |                    |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |                | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |                    |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>4/9/</u> , 19 <u>68</u> , to <u>4/9/</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>4/9/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |                |   |  |   |                    |
| 22b. SIGNATURE<br><u>Warren W. Wurzbacher</u> M.D.  |  | 22c. DATE SIGNED<br>April 10, 1968  |                | 22d. ADDRESS<br>6720 York Rd., Towson, Md. 21204  |  |   |                    |
| 23a. BURIAL CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br>5/17/68  |                | 23c. NAME OF CEMETERY OR CREMATORY<br>V.O. (Md. Med. School)  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.                                 |                    |
| 24. FUNERAL DIRECTOR  |  | 25a. REC'D BY REGISTRAR<br>DATE<br>MAY 20, 1968   |                | 25b. REGISTRAR'S SIGNATURE  |  |   |                    |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05276

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item # 23b & 23c film # G401 50

05277

|  |  |  |  |   |  |   |  |  |
|--|--|--|--|---|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) Charles Leonard King   |  |  | 2a. DATE OF DEATH<br>Month Day Year April 22, 1968   |   |  | 2b. HOUR<br>3:50 P.M.   |  |  |
| 3. SEX<br>male   |  | 4. RACE<br>Negro   |  | 5. DATE OF BIRTH<br>Aug. 1, 1911  |  | 6. AGE (In years last birthday)<br>56 YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>S. C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>SPRING GROVE STATE HOSP. |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  |  | 13b. COUNTY<br>BALTO.  |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>721 S. Hanover St. |  |
| 14. FATHER'S NAME First Middle Last<br>Rich King   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Adelaide Monroe  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>Records: SPRING GROVE STATE HOSPITAL                                |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1621 Squamous Cell Carcinoma of the Lung, left upper lobe Bronchus, with Metastases<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>none/1621   |  |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                    |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from May 26, 1967, to April 22, 1968, that (X) (we) last saw the deceased alive on April 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (do) (did not) view the body after death.   |  |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br>Anthony J. Young, M.D.   |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>            |  | 22c. DATE SIGNED<br>4-22-68   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Anthony J. Young, M.D.   |  |  |  | 22e. ADDRESS<br>SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br>4/29/68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Anatomy Board   |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE Arn 25 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |

VR A15 (4)  
30M REV. 1/68

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EXHIBIT OF CASE

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form - Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |                         |  |  |   |   |   |   |   |  |
|---|-------------------------|--|--|---|---|---|---|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |  |  |   |   |   |   |   |  |
| 1. DECEASED-NAME<br>(Type or Print) <b>JAMES P. KLINE</b>   |                         |  | First Middle Last  |   |   | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> Month Day Year 19 |   |   | 2b. HOUR<br>M                                      |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>July 3, 1896</b>  | 6. AGE (In years<br>last birthday) <b>71</b> YRS.                              | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year 19 <b>April 15, 1968</b>                             |   |   | 2d. HOUR<br><b>9:35 PM</b>                         |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Penna.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>1025 Eastern Avenue</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) <b>Miner</b> |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY <b>Coal Mine</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Md.</b>   |                         |  | 13b. COUNTY <b>Baltimore</b>   |   | 13c. CITY OR TOWN <b>Essex</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>1025 Eastern Ave.</b> |
| 14. FATHER'S NAME<br><b>Nicholas Kline</b>  |                         |  | First Middle Last  |   |   | 15. MOTHER'S MAIDEN NAME<br><b>Eliza Simmons</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b>  |                         |  | 16b. SOCIAL SECURITY NO.<br>(If yes, give year or dates of service) <b>WWI</b> |   | 17. INFORMANT<br><b>Anna Kline</b>  |   | ADDRESS<br><b>Same</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b><br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.  |                         |  |  |   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>4201</b>  |                         |  |  |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |                         |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                           |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/><br>CAUSE OF DEATH   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |                         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)                            |  | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |   | County  | State  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |  |   |   |   |   |   |  |
| ACTUAL<br>SIGNATURE <b>Theo. C. Patterson</b>   |                         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                |   |   | 22b. DATE SIGNED <b>4/15/68</b>   |   |   |  |
| EXAMINER'S<br>NAME (Type) <b>Theo. C. Patterson, M.D. 105 Main St. Dundalk, Md. 21222</b>   |                         |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                            |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                     |   |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Removal</b>  |                         | 23b. DATE<br><b>4/17/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Beck Funeral Home</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Portage, Penna.</b>                         |   |  |
| 24. FUNERAL DIRECTOR<br><b>Bruzdzinski Funeral Home 1407 Eastern Ave.</b>   |                         |  |  | ADDRESS   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 18 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>    |  |

85330

MANITOBA PROVINCE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 7-68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |   |  |  |   |  |
|--|--|--|---|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |   |  |  |   |  |
| CERTIFICATE OF DEATH   |  |  |   |  |   |  |  |   |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><i>St. Mary Rosalia Khinzin</i>  |  |  | 2a. DATE OF DEATH Month Day Year<br><i>4 - 9 - 1968</i>           |  |   | 2b. HOUR<br><i>4 5 PM</i>  |  |   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>  |   | 5. DATE OF BIRTH<br><i>1-16-1916</i>   |   | 6. AGE (In years last birthday)<br><i>52</i> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.       |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Germany</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Glen Arm, Md.</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Glen Arm Road</i> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Teacher</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>EDUCATION</i>                |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>  |  | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>Glen Arm Rd.</i>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER  |  |
| 14. FATHER'S NAME First Middle Last<br><i>Michael Khinzin</i>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>Amalia Frank</i> |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)<br><i>no</i>  |  |  | 16b. SOCIAL SECURITY NO.<br><i>320-54-9334</i>                    |  | 17. INFORMANT<br><i>St. M. Kathleen</i>   |  | Address<br><i>same</i>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4109 Congestive Heart Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary occlusion</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary occlusion</i>                                  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>6 days</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><i>4201</i>  |  |  |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11-10, 1966</i> , to <i>4-4, 1968</i> , that (I) (we) last saw the deceased alive on <i>4-4, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |  |  |   |  |
| 22b. SIGNATURE<br><i>Henry L. McCorkle MD</i>  |  | DEGREE<br><i>MD</i>  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |   | 22c. DATE SIGNED<br><i>4-10-68</i>   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>HENRY L. MCCORKLE MD</i>  |  | 22e. ADDRESS<br><i>Phoenix, Maryland 21131</i>   |   |  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>   |  | 23b. DATE<br><i>APRIL 11, 1968</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>SISTERS CEMETERY</i>  |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Glen Arm Balt Maryland</i>               |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>RAYMOND CURREN</i>  |  | ADDRESS<br><i>817 SCARLETT DR TOWSON, MD 21204</i>   |   | 25a. REC'D BY REGISTRAR<br><i>DATE APR 18 1968</i>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |   |  |

1938

CHARTER OF 1938

1938

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Handwritten text, likely a charter or agreement, covering the remaining paragraphs of the document.

APR 18 1938

Vertical text on the right margin, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |  |                         |   |  |
|---|--|--|--|--|--|--|-------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |                         |   |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |  |                         |   |  |
| 1. DECEASED-NAME (Type or print) <b>MARIE</b> First <b>M.</b> Middle <b>KOENIG</b> Last   |  |  |  |  | 2a. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>17</b> Year <b>1968</b> |  | 2b. HOUR <b>5 P. M.</b> |   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>Cau.</b>  |  | 5. DATE OF BIRTH<br><b>Feb. 6, 1886</b>  |  | 6. AGE (In years last birthday) <b>82</b> YRS.   |                         | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.       |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore</b> Md.  |                         |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore 21212</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>513 Castle Drive</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>  |                         |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                         | 13e. STREET AND NUMBER <b>513 Castle Drive</b>                |  |
| 14. FATHER'S NAME First <b>Adam</b> Middle <b>D.</b> Last <b>Miller</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>Elizabeth</b> Middle <b>Reese</b> Last   |  |  |                         |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <b>No</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO. <b>218-18-7940</b>  |  | 17. INFORMANT Address <b>Mr. Henry A. Koenig, Trappe, Maryland</b>   |  |  |                         |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4129</b> IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |  |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4200 Generalized arterio sclerosis</b>   |  |  |  |  |  |  |                         |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                         |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. <b>19</b>                                    |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |                         |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |                         |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>June - 2 - 1967</b> , to <b>April 17, 1968</b> , that (I) (we) last saw the deceased alive on <b>April 11 - 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                      |  |  |  |  |  |  |                         |   |  |
| 22b. SIGNATURE <b>Earl L. Chambers, M.D.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  | 22c. DATE SIGNED <b>April 19, 1968</b>   |  |  |                         |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Earl L. Chambers - M. D.</b>  |  |  |  | 22e. ADDRESS <b>4105 Liberty Hgts., Baltimore, Maryland</b>  |  |  |                         |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE <b>Apr. 20, 1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>                     |                         |   |  |
| 24. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland</b>   |  |  |  | 25a. REC'D BY REGISTRAR DATE <b>APR 23 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>  |                         |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |   |  |   |  |                                |  |
|---|--|---|--|---|--|---|--|---|--|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |   |  |   |  |                                |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  |                                |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br>HERMAN   |  | Middle<br>A.  |  | Last<br>KOHLEHOFF   |  | 2a. DATE OF DEATH<br>Month Day Year                                     |  | 2b. HOUR<br>3:50 P M           |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>2-27-89   |  | 6. AGE (In years<br>last birthday)<br>79 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country) Baltimore Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) St. Joseph Hospital |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired) Retired Carpenter   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |   |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE Baltimore  |  | 13b. COUNTY<br>—  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>525 Rossiter Avenue                           |  |                                |  |
| 14. FATHER'S NAME First Middle Last<br>Richard Kohlhoff   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Harriett Loudenslager                                 |  |   |  |   |  |   |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) No   |  | (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Mrs. Mary T. Kohlhoff  |  | Address<br>(Same)   |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |   |  |   |  |   |  |                                |  |
| PART 1. DEATH WAS CAUSED BY:  |  |   |  |   |  |   |  |   |  |                                |  |
| IMMEDIATE CAUSE (a) Pulmonary Embolism  |  |   |  |   |  |   |  |   |  |                                |  |
| 450 X DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |   |  |                                |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |   |  |   |  |   |  |   |  |                                |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |   |  |                                |  |
| (c)   |  |   |  |   |  |   |  |   |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |   |  |   |  |                                |  |
| 465 X   |  |   |  |   |  |   |  |   |  |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                     |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-5-1968, to 4-8-1968, that (I) (we) last saw the deceased alive on 4-8-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |                                |  |
| 22b. SIGNATURE<br>Paglinauan  |  | DEGREE  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br>4-8-1968  |  |   |  |                                |  |
| 22d. PHYSICIAN'S NAME (Type) Eodula Paglinauan Jr.  |  | 22e. ADDRESS<br>St Joseph Hospital  |  |   |  |   |  |   |  |                                |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify) Burial   |  | 23b. DATE<br>4/12/68.   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Joseph's Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Texas, Md.                                     |  |   |  |                                |  |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck, Inc. Balto. Md. 21214  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE APR 9 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |   |  |                                |  |





FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05278

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|   |                  |  |  |  |   |   |  |   |   |        |       |
|---|------------------|--|--|--|---|---|--|---|---|--------|-------|
| 1. DECEASED-NAME<br>(Type or Print) <i>GRADYS AGOSTA KOPP</i>   |                  |  | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month <i>4</i> Day <i>16</i> Year <i>1968</i> |  |   | 2b. HOUR <i>12:00</i> M <i>P</i>  |  |   |   |        |       |
| 3. SEX <i>F</i>   | 4. RACE <i>W</i> | 5. DATE OF BIRTH <i>5-23-17</i>  | 6. AGE (in years last birthday) <i>50</i> YRS.   | IF UNDER 1 YEAR<br>MONTHS <i>0</i> DAYS <i>0</i>   | IF UNDER 24 HRS.<br>HOURS <i>0</i> MIN. <i>0</i>                                | 2c. DATE PRONOUNCED DEAD<br>Month <i>4</i> Day <i>16</i> Year <i>1968</i> |  |   | 2d. HOUR <i>12:00</i> M <i>P</i>                              |        |       |
| 7a. BIRTHPLACE (State or foreign country) <i>Waxton West Virginia</i>   |                  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <i>BALTIMORE</i> Md.                                   |  |   |   |        |       |
| 10. CITY OR TOWN OF DEATH <i>Randallstown Md</i>  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>BALTO Co. GENERAL HOSP</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>REGISTERED NURSE</i>  |   | 12b. KIND OF BUSINESS OR INDUSTRY <i>Med. ed.</i>                         |  |   |   |        |       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>   |                  |  | 13b. COUNTY <i>Balto.</i>  |  | 13c. CITY OR TOWN <i>—</i>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER <i>3216 Rolling Road</i>               |        |       |
| 14. FATHER'S NAME First <i>Thomas H.</i> Middle <i>—</i> Last <i>Lowr</i>   |                  |  | 15. MOTHER'S MAIDEN NAME First <i>Myrtle</i> Middle <i>—</i> Last <i>—</i>                       |  |   |   |  |   |   |        |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>   |                  |  | 16b. SOCIAL SECURITY NO. <i>527-28-5464</i>  |  | 17. INFORMANT <i>Mr. Hannu W. Kopp Jr.</i>                                      |   |  | ADDRESS <i>Balto Md 3216 Rolling Rd 21207</i>   |   |        |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>9500 RESPIRATORY FAILURE</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Overdose of Hypnophyll (BARBITURATE)</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>—</i>   |                  |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>4 days</i> |        |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><i>9702</i>  |                  |  |  |  |   |   |  |   |   |        |       |
| 19a. DATE OF OPERATION  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |   |        |       |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <i>19</i> P.M.                                 |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |   |   |        |       |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                               |  |  | 21f. LOCATION Street or R.F.D. No.  |   |  | City or Town                                    |   | County | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |  |  |  |   |   |  |   |   |        |       |
| ACTUAL SIGNATURE <i>J. Nelson McKay</i>   |                  |  | M.D.   |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                           |  |   | 22b. DATE SIGNED <i>4/26/68</i>                               |        |       |
| EXAMINER'S NAME (Type) <i>J. NELSON MCKAY, M.D.</i>   |                  |  |  |  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>               |  |   | ADDRESS (Street, city, town, or county)                       |        |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |                  | 23b. DATE <i>4/18/68</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Balto. National</i>  |   |   | 23d. LOCATION (City or Town) <i>Balto.</i> (County) <i>Stad.</i> (State)                     |   |   |        |       |
| 24. FUNERAL DIRECTOR <i>Loring Byers-8728 Liberty Road Randallstown Md</i>  |                  |  |  | ADDRESS  |   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> |   |        |       |
|   |                  |  |  |  |   | DATE <i>APR 19 1968</i>   |  |   |   |        |       |

8228

RECEIVED IN 1950

8228

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 05280  |   |   | 05283   |   |  |
| 1. DECEASED-NAME (Type or print)<br>First Middle Last<br><b>Anna Louise Korman</b>   |   |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>April 7, 1968</b>       |   | 2b. HOUR<br><b>2 P M</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>                       | 5. DATE OF BIRTH<br><b>Feb. 1, 1875</b>   |   | 6. AGE (In years last birthday)<br><b>93</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                        |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Reisterstown</b>   |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Berrymans Lane</b>   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Reisterstown</b>                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             | 13e. STREET AND NUMBER<br><b>Berrymans Lane</b>                  |
| 14. FATHER'S NAME First Middle Last<br><b>Samuel France</b>  |   |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Sarah Murray</b> |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>217-48-6147</b>  |   | 17. INFORMANT Address<br><b>Charles W. Korman Berrymans Lane Reisterstown, Md.</b>                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic C-V Disease</b><br><b>4129</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b> |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221</b>  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |   |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)<br><b>none</b>  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>none</b> 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>none</b>              |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-16-45</b> , 19__, to <b>4-7-68</b> , 19__, that (I) (we) last saw the deceased alive on <b>3-21-68</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>D. D. Caples M.D.</b>   |   |   |   | 22c. DATE SIGNED<br><b>Apr. 9, 1968</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>D. D. Caples, M. D.</b>   |   |   |   | 22e. ADDRESS<br><b>6 Hanover Rd., Reisterstown, Md. 21136</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |   | 23b. DATE<br><b>April 10, 1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>All Saints Cemetery</b>  |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Reisterstown Balto., Md.</b>   |   |   |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>H. J. Eckhardt</b>  |   | ADDRESS<br><b>Owings Mills, Md.</b>   |   | 25a. REGISTERED<br><b>APR 10 1968</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. J. Judge</b>   |   |   |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

35286

DEPARTMENT OF HEALTH

35286

March 7, 1928

Received

From

of

Feb. 1, 1927

Walter

Walter

Residence

Age

Occupation

Married

Single

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

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Married

Married

Married

Married

Married

Married

Married

Married

Married

W. A. Taylor

March 10, 1928

W. A. Taylor

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 05281 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |                  |  |   |   |   |   |  |   |   | 05284   |  |  |
|---|------------------|--|---|---|---|---|--|---|---|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                  |  |   |   |   |   |  |   |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or Print) <b>LYNN</b> First <b>TITMSEN</b> Middle <b>KREEGER</b> Last   |                  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>APR</b> Day <b>21</b> Year <b>1968</b> |   |   | 2b. HOUR <b>3:40</b> AM   |  |   |   |   |  |  |
| 3. SEX <b>M</b>   | 4. RACE <b>W</b> | 5. DATE OF BIRTH <b>11-17-39</b>   | 6. AGE (In years last birthday) <b>28</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS   | IF UNDER 24 HRS<br>HOURS<br>MIN.  | 2c. DATE PRONOUNCED DEAD <b>APR</b> Day <b>21</b> Year <b>1968</b>        |  | 2d. HOUR <b>3:40</b> AM                             |   |   |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>   |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>BALTIMORE</b>                                       |  |   |   | Md.   |  |  |
| 10. CITY OR TOWN OF DEATH <b>TOWSON</b>   |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSP.</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>SALES MAN</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>  |                  |  | 13b. COUNTY <b>BALTO.</b>   |   | 13c. CITY OR TOWN <b>COCKEYSVILLE</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER <b>202 DUKE OF KENT LANE</b> |   |  |  |
| 14. FATHER'S NAME First <b>JAMES</b> Middle <b>S.</b> Last <b>KREEGER</b>   |                  |  | 15. MOTHER'S MAIDEN NAME First <b>DEBORAH</b> Middle <b>BROWN</b> Last                                      |   |   |   |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>   |                  |  | 16b. SOCIAL SECURITY NO. <b>220-32-7741</b>   |   | 17. INFORMANT <b>NOEL D. KREEGER</b>  |   | ADDRESS <b>202 DUKE OF KENT LANE</b>   |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>COMPOUND FRACTURE BASE OF SKULL</b><br><b>819.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |                  |  |   |   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>2254</b>  |                  |  |   |   |   |   |  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |   |   |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>4/21</b> 1968<br>P.M.                           |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)<br><b>DRIVER OF CAR</b>   |   |   |  |   |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>HIGHWAY</b>       |   | 21f. LOCATION Street or R.F.D. No. <b>HARRISBURG EPNY RD.</b>   |   | City or Town <b>WINDY MIT. CHERRY RD.</b>                                 |  | County <b>BALTO.</b>                                |   | State <b>MD.</b>  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                  |  |   |   |   |   |  |   |   |   |  |  |
| ACTUAL SIGNATURE <b>William A. Pillsbury</b> M.D.   |                  |  |   |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                           |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |  |
| EXAMINER'S NAME (Type) <b>William A. Pillsbury</b>  |                  |  |   |   |   | ADDRESS (Street, City, Town, or County) <b>Towson, Md.</b>                |  | 22b. DATE SIGNED <b>4-21-68</b>                     |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                  | 23b. DATE <b>4/23/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL CEM.</b>  |   | 23d. LOCATION (City or Town) <b>BALTIMORE</b> (County) <b>MD.</b> (State) |  |   |   |   |  |  |
| 24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks TOWSON</b>  |                  |  |   | ADDRESS <b>1050 YORK RD. 21204</b>  |   | 25a. REC'D BY REGISTRAR <b>APR 25 1968</b>                                |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>     |   |   |  |  |

1228\*

WORLD'S FAIR, 1904, ST. LOUIS, MO.

1228\*





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                  |  |  |   |  |  |  |
|---|------------------|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>FREDERICK J. KROLL</b>   |                  | First Middle Last  |  | 2a. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>APR 3 1968</b>              |  | 2b. HOUR <b>8:18 M</b>   |  |
| 3. SEX <b>M</b>   | 4. RACE <b>W</b> | 5. DATE OF BIRTH <b>7/13/05</b>  | 6. AGE (In years last birthday) <b>62 YRS.</b> | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>  | IF UNDER 24 HRS<br>HOURS <input type="checkbox"/> MIN <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD<br>Month <b>4</b> - Day <b>3</b> Year <b>1968</b>                   |  |
| 7a. BIRTHPLACE (State or foreign country) <b>MD.</b>  |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>BALTO</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>ESSEX</b>  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) <b>305 SO. TAYLOR</b>                 |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>OIL</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>  |                  | 13b. COUNTY <b>BALTO</b>   |  | 13c. CITY OR TOWN <b>ESSEX</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME First Middle Last <b>JACOB F. KROLL</b>   |                  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>DORA KACKER</b>  |  | 13e. STREET AND NUMBER <b>305 SO. TAYLOR</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>UNK</b>   |                  | 16b. SOCIAL SECURITY NO. <b>214-01-4587</b>  |  | 17. INFORMANT ADDRESS <b>FLORENCE KROLL</b>   |  | 17b. ABOVE   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>A-5-C-V-DISEASE</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF  |                  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>422.1</b>   |                  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>None</b>  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> <b>19</b> |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>M.B. Davis MD.</b>  |                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                  |  |
| EXAMINER'S NAME (Type) <b>M.B. DAVIS MD.</b>  |                  | 22b. DATE SIGNED <b>4/5/68</b>   |  | 22c. DATE SIGNED <b>4/5/68</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                  | 23b. DATE <b>4/6/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>                              |  |
| 24. FUNERAL DIRECTOR <b>J.G. CONNELLY SONS</b>  |                  | ADDRESS <b>300 MACE</b>  |  | 25a. REC'D BY REGISTRAR <b>APR 8 - 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |

28281

28282

28283

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |                                   |  |
|---|--|--|--|---|--|---|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |                                   |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |                                   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle  |  | Last  |  | 2a. DATE OF DEATH                 |  |
| ELLEN   |  |  |  | KRUUSMAGI   |  |   |  | Month Day Year<br>April 6, 1968   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | 2b. HOUR                          |  |
| Female  |  | White  |  | November 24, 1901   |  | 66 YRS.   |  | 5:00 AM                           |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                                   |  |
| Estonia   |  | U.S.A.   |  |   |  | Baltimore   |  | Md.                               |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                   |  |
| Towson  |  | St. Joseph Hospital  |  | Homemaker   |  |   |  |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER            |  |
| STATE Maryland  |  | Baltimore  |  | Timonium  |  |   |  | 1811 Vista Lane, 21093            |  |
| 14. FATHER'S NAME   |  | First  |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME          |  |
| Wilhem  |  | Kaptein  |  |   |  |   |  | Leena Kimberg                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | Address   |  |                                   |  |
| No  |  | 150-24-3248  |  | Mrs. Helen Eichhorn   |  | 1811 Vista Lane   |  | 21093                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Metastasis of pelvic malignancy to lungs</u>                          |  |  |  |   |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |                                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION   |  | Street or R.F.D. No.  |  | City or Town                      | County                                       |
|   |  |  |  |   |  |   |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 23, 1968</u> , to <u>April 6, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 6, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |                                   |  |
| 22b. SIGNATURE<br><u>Dr. Stuart Sunday / Yusup Oh</u>   |  |  |  |   |  |   |  | 22c. DATE SIGNED<br>April 6, 1968 |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Dr. Stuart Sunday / Yusup Oh, M.D.  |  |  |  | 22e. ADDRESS<br>7620 York Rd. Towson, Md. 21204   |  |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)  |  | (County)                          | (State)                                      |
| Burial  |  | 4/10/68  |  | Woodlawn Cemetery   |  | Lakewood, Ocean Co.   |  | N.J.                              |  |
| 24. FUNERAL DIRECTOR  |  |  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE        |  |
| Wm. Cook-Brooks   |  |  |  | Towson 1050 York Rd. Towson, Md. 21204  |  | APR 8 - 1968  |  | Charles Judge                     |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)  
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                           |  |  |              |  |  |                           |  |  |      |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|---|--|--|---------------------------|--|--|--------------|--|--|---------------------------|--|--|------|--|--|
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                           |  |  |              |  |  |                           |  |  |      |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br>EVA   |  |  | Middle<br>G.  |  |  | Last<br>LAND  |  |  | 2a. DATE OF DEATH<br>Month<br>APRIL         |  |  | Day<br>12                 |  |  | Year<br>1968 |  |  | 2b. HOUR<br>8:22          |  |  | AM   |  |  |
| 3. SEX<br>FEMALE   |  |  | 4. RACE<br>WHITE   |  |  | 5. DATE OF BIRTH  |  |  | 6. AGE (In years<br>last birthday)<br>71  |  |  | YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS |  |  | DAYS         |  |  | IF UNDER 24 HRS.<br>HOURS |  |  | MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>BALTIMORE, MD.   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>BALTIMORE Md.   |  |  |   |  |  |                           |  |  |              |  |  |                           |  |  |      |  |  |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>SHANGRI-LA NURSING HOME |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>HOUSEWIFE   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>AT HOME   |  |  |   |  |  |                           |  |  |              |  |  |                           |  |  |      |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>MARYLAND   |  |  | 13b. COUNTY<br>BALTIMORE   |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>8203 MARCIE DRIVE |  |  |                           |  |  |              |  |  |                           |  |  |      |  |  |
| 14. FATHER'S NAME<br>First<br>LOUIS  |  |  | Middle<br>GERBER   |  |  | Last  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>JENNIE   |  |  | Middle<br>ROSENBLUM                         |  |  | Last                      |  |  |              |  |  |                           |  |  |      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>NO  |  |  | (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br>212-42-7415   |  |  | 17. INFORMANT<br>Address<br>MR. PAUL LAND, 8203 MARCIE DRIVE, #8                                |  |  |   |  |  |                           |  |  |              |  |  |                           |  |  |      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized A.S.C.V.D. - CVA</u><br>4129 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>2-3 hrs |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                           |  |  |              |  |  |                           |  |  |      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>4221 <u>Bronchitis, Bronchitis, Asthma</u>  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                           |  |  |              |  |  |                           |  |  |      |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |   |  |  |                           |  |  |              |  |  |                           |  |  |      |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |   |  |  |                           |  |  |              |  |  |                           |  |  |      |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                            |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |   |  |  |                           |  |  |              |  |  |                           |  |  |      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>4/11</u> , 19 <u>68</u> , that (I) (we) lost<br>saw the deceased alive on <u>4/11</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                           |  |  |              |  |  |                           |  |  |      |  |  |
| 22b. SIGNATURE<br><u>Morton J. Ellin</u>   |  |  | DEGREE   |  |  | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>                    |  |  | 22c. DATE SIGNED<br><u>4/12/68</u>  |  |  |   |  |  |                           |  |  |              |  |  |                           |  |  |      |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>MORTON J. ELLIN   |  |  | 22e. ADDRESS<br>8629 LIBERTY ROAD  |  |  |   |  |  |   |  |  |   |  |  |                           |  |  |              |  |  |                           |  |  |      |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL   |  |  | 23b. DATE<br>4-14-68   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CHIZUK AMUNO (ARLINGTON)  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MARYLAND                            |  |  |   |  |  |                           |  |  |              |  |  |                           |  |  |      |  |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS. INC.  |  |  | ADDRESS<br>6010 REISTERSTOWN ROAD, BALTO. 21215  |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br>APR 16 1968  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |   |  |  |                           |  |  |              |  |  |                           |  |  |      |  |  |

03381

ST. LOUIS DE MARY

03381

03381 71



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-54-1  
30M REV. 1-1968

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |                        |  |
|---|--|--|--|--|--|---|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |                        |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |                        |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle   |  | Last  |  | 2a. DATE OF DEATH      |  |
| William   |  |  |  |  |  | Lee   |  | April 25, 1968         |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years lost birthday)   |  | 2b. HOUR               |  |
| Male  |  | white  |  | October 1, 1886  |  | 81 YRS.   |  | 9:45 PM                |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                        |  |
| Md.   |  | U.S.A.   |  |  |  | Baltimore County  |  | Md.                    |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                        |  |
| Catonsville   |  | Spring Grove State Hospital  |  | Shipping clerk   |  |   |  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER |  |
| Maryland  |  |  |  | Baltimore  |  |   |  | 201 Callow Avenue      |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                        |  |
| Benjamin  |  | Catherine Bond   |  |  |  |   |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |   |  |                        |  |
|   |  | 219-54-3208-J1   |  | Records: Spring Grove State Hospital   |  |   |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |                        |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction, recto-sigmoid area, 2 days.</u>   |  |  |  |  |  |   |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>etiology undetermined</u>   |  |  |  |  |  |   |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>5609</u>  |  |  |  |  |  |   |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerotic Cardiovascular Heart Disease.</u>  |  |  |  |  |  |   |  |                        |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town  |  | County State           |  |
| 22a. I certify that (X) (this hospital) attended the deceased from March 11, 1956, to April 25, 1968, that (X) (we) last saw the deceased alive on April 25, 1968, and that in (my) (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                        |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  |  |  |   |  |                        |  |
| Anthony J. Young, M.D.  |  | April 26, 1968   |  |  |  |   |  |                        |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |  |  |   |  |                        |  |
| Anthony J. Young, M.D.  |  | Spring Grove State Hospital  |  |  |  |   |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)                                     |  |                        |  |
| Burial  |  | 6/7/68   |  | London Park  |  | Balt. Md.   |  |                        |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |                        |  |
| E.S. Macnab   |  | 301 Frederick Rd   |  | DATE JUN 10 1968   |  | Charles Judge   |  |                        |  |

27228

38736

U.S. DEPT. OF JUSTICE

38736

1

INVESTIGATION OF THE

ALLEGED

RECENT ACTS OF VIOLENCE

AND

DISORDERLY CONDUCT

IN THE DISTRICT OF COLUMBIA

AND

ADJACENT AREAS

AND THE EFFECTS THEREOF

ON THE COMMUNITY

AND THE

RECOMMENDATIONS

FOR

THE FUTURE

OF

THE DISTRICT

OF COLUMBIA AND ADJACENT AREAS

AND

THE EFFECTS THEREOF

ON THE COMMUNITY

AND THE EFFECTS THEREOF

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)  
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                              |   |   |   |  |  |  |  |
|---|--|------------------------------|---|---|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                              |   |   |   |  |  |  |  |
| CERTIFICATE OF DEATH  |  |                              |   |   |   |  |  |  |  |
| 1. DECEASED NAME<br>(Type or print)<br><b>Eugene Eugene</b>   |  |                              | First Middle Last<br><b>Leight</b>  |   |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>4 16 68</b>  |  |  | 2b. HOUR<br><b>7:42 PM</b>                                       |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>          |   | 5. DATE OF BIRTH<br><b>8-17-85</b>  |   |  | 6. AGE (In years lost birthday)<br><b>82</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Glenn Arm Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTO</b> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GREATER BALTO Med. Cen</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired</b>                              |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>616 Woodbine Ave</b>  |  |                              | 13b. COUNTY<br><b>BALTO</b>   |   | 13c. CITY OR TOWN<br><b>21204</b>                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |
| 14. FATHER'S NAME<br>First Middle Last<br><b>John X Leight</b>  |  |                              | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Owens, Mary E.</b>  |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>No</b>  |  |                              | 16b. SOCIAL SECURITY NO.<br><b>218-22-1546A</b>   |   | 17. INFORMANT<br><b>Hospital Records</b>                    |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Complete Heart Block</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>severe CHF</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>arteriosclerotic Heart disease</b> |  |                              |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4200</b>   |  |                              |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-15</b> , 19 <b>68</b> , to <b>4-16</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>4-16</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |                              |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>L E L I A C. BALDONADO</b>   |  |                              |   |   |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4-16-68</b>                                   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>L I L I A C. BALDONADO</b>   |  |                              |   |   |   | 22e. ADDRESS<br><b>G B M C</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                              | 23b. DATE<br><b>4.19.68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b> |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cockeysville, Md.</b>            |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Wm. Cook-Brooks Towson, Towson, Md. 21204</b>   |  |                              |   |   |   | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 18 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 05287  |  |  |  |  |  |  |  |   |  |  |  | 05289   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|---|--|---|--|------------------|--|--|--|------------------------|--|--|--|--|--|
| DIVISION OF VITAL RECORDS; 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |   |  |  |  | CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |  |  | First Middle Last  |  |   |  |  |  | 2a. DATE OF DEATH   |  |  |  |   |  | 2b. HOUR  |  |                  |  |  |  |                        |  |  |  |  |  |
| Larry Keith  |  |  |  |  |  | LeMOINE, Jr.   |  |   |  |  |  | Month 4 Day 22 Year 68  |  |  |  |   |  | 1:25PM  |  |                  |  |  |  |                        |  |  |  |  |  |
| 3. SEX   |  |  |  | 4. RACE  |  |  |  | 5. DATE OF BIRTH  |  |  |  | 6. AGE (In years lost birthday)   |  |  |  | IF UNDER 1 YEAR                             |  |   |  | IF UNDER 24 HRS. |  |  |  |                        |  |  |  |  |  |
| Male   |  |  |  | Caucasian  |  |  |  | March 8, 1968   |  |  |  | YRS. 1 MONTHS 14 DAYS   |  |  |  | HOURS MIN.                                  |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH  |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| Baltimore  |  |  |  | USA  |  |  |  |   |  |  |  | Baltimore Md.   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                  |  |  |  |                        |  |  |  |  |  |
| Towson   |  |  |  |  |  | GREATER BALTO. MED. CENTER   |  |   |  |  |  |   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  |  |  | 13b. COUNTY  |  |   |  |  |  | 13c. CITY OR TOWN   |  |  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                  |  |  |  | 13e. STREET AND NUMBER |  |  |  |  |  |
| Maryland   |  |  |  |  |  | Baltimore  |  |   |  |  |  |   |  |  |  |   |  | 8316 Nunley Drive, Apt. E   |  |                  |  |  |  |                        |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |   |  |  |  |   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| Larry Keith Le Moine   |  |  |  |  |  | Janice Faye Davis  |  |   |  |  |  |   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)   |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |   |  |  |  | 17. INFORMANT Address   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
|  |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Hypertrophic pyloric stenosis  |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| 7501 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| (c)  |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| 7560   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES                |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.                         |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/8, 1968, to 4/23, 1968, that (I) (we) lost the deceased alive on 4/23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| 22b. SIGNATURE John E. Adams DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |   |  |  |  | 22c. DATE SIGNED 4/23/68  |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) John E. Adams, M.D.   |  |  |  |  |  |  |  |   |  |  |  | 22e. ADDRESS Greater Baltimore Medical Center   |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  | 23b. DATE 4/25/68  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY G.B.M.C.   |  |  |  | 23d. LOCATION (City or Town) (County) (State) Towson, Balto. Md.                        |  |  |  |   |  |   |  |                  |  |  |  |                        |  |  |  |  |  |
| 24. FUNERAL DIRECTOR John E. Adams, M.D. ADDRESS G.B.M.C.  |  |  |  |  |  |  |  |   |  |  |  | 25a. REC'D BY REGISTRAR DATE APR 30 1968  |  |  |  | 25b. REGISTRAR'S SIGNATURE J. Charles Judge |  |   |  |                  |  |  |  |                        |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>MOSES</b>  |  | First Middle Last <b>LEVIN</b>  |  | 2a. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>25</b> Year <b>68</b>  |  | 2b. HOUR <b>11:40</b>  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br><b>1902</b>   |  | 6. AGE (In years last birthday)<br><b>66</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>RUSSIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>PIKESVILLE</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>MILFORD MANOR NURSING HOME</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>STATIONARY</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETAIL</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>   |  | 13b. COUNTY <b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>8402 MERRYMOUNT DR.</b>  |  | 14. FATHER'S NAME<br>First Middle Last<br><b>JACOB ?</b>  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>SARAH ?</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>NO</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>217-32-7728</b>  |  | 17. INFORMANT<br><b>MRS. JENNIE SPJUT</b>   |  | Address<br><b>8402 MERRYMOUNT DR.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Disease</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Carcinoma of prostate</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 years</b><br><b>9 years</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4200</b><br><b>None</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 22, 1962</b> , to <b>April 25, 1968</b> , that (I) (we) last saw the deceased alive on <b>April 25, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Manuel Levin</b>   |  | 22c. DATE SIGNED<br><b>4/25/68</b>  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>MANUEL LEVIN</b>   |  |  |  |
| 22e. ADDRESS<br><b>6101 PARK HEIGHTS AVE MD</b>   |  | 22f. ADDRESS  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4-28-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WORKMENS CIRCLE</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                  |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS. INC.</b>  |  | 24b. ADDRESS<br><b>6010 REISTERSTOWN ROAD, BALTO. 21215</b>   |  | 25a. RECEIVED BY REGISTRAR<br><b>APR 30 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (A)  
30M REV 1/68

MEDICAL CERTIFICATION

|   |  |   |  |  |   |   |                                |
|---|--|---|--|--|---|---|--------------------------------|
| 05288   |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   | 05291   |                                |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br>CHARLES  | Middle<br>MARSHALL   | Last<br>LEWIS  | 2a. DATE OF DEATH<br>April Month 16, Day 1968 |   | 2b. HOUR<br>1:57 P.M.          |
| 3. SEX<br>Male  | 4. RACE<br>White                       | 5. DATE OF BIRTH<br>10-1-1885   |  |  | 6. AGE (In years<br>last birthday)<br>82 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Virginia  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore  |   | Md.   |                                |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>House in the Pines   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Retired  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |                                |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Arbutus                               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET AND NUMBER<br>930 Leeds Avenue    |   |                                |
| 14. FATHER'S NAME First Middle Last<br>William M. Lewis   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Susanna Carr |  |   |   |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br>577-12-7218   |  | 17. INFORMANT Address<br>Mrs. Flora S. Lewis, 930 Leeds Avenue 21229   |   |   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u><br>185X DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a).<br>stating the underlying cause<br>last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>7 yrs.               |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>177X Arteriosclerotic cardiovascular disease  |  |   |  |  |   |   |                                |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 3, 1953, to April 16, 1968, that (I) (we) last<br>saw the deceased alive on April 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |   |                                |
| 22b. SIGNATURE<br>John Nesbitt J. Jr.   |  |   |  | DEGREE ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>4-17-68   |                                |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Dr. John A. Nesbitt, Jr.   |  | 22e. ADDRESS<br>1009 Frederick Road, Catonsville, Md.   |  |  |   |   |                                |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Type)<br>BURIAL   |  | 23b. DATE<br>4-19-1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery   |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland    |                                |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Howard H. Hubbard, 4107 Wilkens Ave. 21229   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE APR 18 1968  |   | 25b. REGISTRAR'S SIGNATURE<br>J. Charles Judge                          |                                |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and send them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MIDDLE  |  |  |  |  |  |  |  |  |  | LAST   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | 3. SEX   |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years lost birthday) |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN |  |  |  |  |  |  |  |  |  |
| MERRILL   |  |  |  |  |  |  |  |  |  | Male   |  |  |  |  |  |  |  |  |  | White  |  |  |  |  |  |  |  |  |  | December 14, 1898  |  |  |  |  |  |  |  |  |  | April 26, 1968                  |  |  |  |  |  |  |  |  |  | 12:10 AM                    |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Ohio  |  |  |  |  |  |  |  |  |  | USA  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |  |  |  |  |  | Md.                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Towson  |  |  |  |  |  |  |  |  |  | St. Joseph Hospital  |  |  |  |  |  |  |  |  |  | retired  |  |  |  |  |  |  |  |  |  | Penna. R.R.  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER          |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |  |  |  |  |  |  |  | BALTO  |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |  |  |  |  |  |  |  |  | 420 Maryland Ave. 21221         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| WILLIAM LEWIS   |  |  |  |  |  |  |  |  |  | ADA REED   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | Address  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| UNK   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | BEATRICE LEWIS   |  |  |  |  |  |  |  |  |  | ABOVE  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Cerebral Thrombosis   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 4129  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |  |  | (b) Arteriosclerotic Cardiovascular Disease                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | (c)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 4221  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 18, 1968, to April 26 19 68, that (I) (we) last saw the deceased alive on April 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  |  |  | DEGREE   |  |  |  |  |  |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Eduardo Montelibano, M.D.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 7620 York Rd.. Towson, Maryland 21204  |  |  |  |  |  |  |  |  |  | April 26, 1968   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| BURIAL  |  |  |  |  |  |  |  |  |  | 4/29/68  |  |  |  |  |  |  |  |  |  | HOLLY HILL   |  |  |  |  |  |  |  |  |  | BALTO. MD.   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| J. J. Connelly  |  |  |  |  |  |  |  |  |  | 300 more   |  |  |  |  |  |  |  |  |  | DATE APR 30 1968   |  |  |  |  |  |  |  |  |  | Charles Judge  |  |  |  |  |  |  |  |  |  |                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|  |                          |  |  |
|--|--------------------------|--|--|
| 05291  |                          | 05293  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last <b>HELEN BONITA Libby</b>   |                          | 2a. DATE OF DEATH Month <b>4</b> Day <b>24</b> Year <b>68</b> 2b. HOUR <b>7:27 PM</b>  |  |
| 3. SEX <b>Female</b>   | 4. RACE <b>Caucasian</b> | 5. DATE OF BIRTH <b>9/25/10</b>  | 6. AGE (In years lost birthday) <b>57</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |
| 7a. BIRTHPLACE (State or foreign country) <b>FLORIDA St Augustine</b>  |                          | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. COUNTY OF DEATH <b>BALTO</b>  |                          | Md.  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO</b>   |                          | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greater Balto Med Center</b>   |  |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>   |                          | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |                          | 13b. COUNTY <b>BALTO</b>   | 13c. CITY OR TOWN <b>BALTO</b>   |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                          | 13e. STREET AND NUMBER <b>920 BARON Ave</b> <b>31221</b>   |  |
| 14. FATHER'S NAME First Middle Last <b>Jerome Capo</b>   |                          | 15. MOTHER'S MAIDEN NAME First Middle Last <b>UNKNOWN - FANNIE ?</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)   |                          | 16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>  | 17. INFORMANT Address <b>Pt's Chart</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>pneumal effusion</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ca. lung with liver metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>1621</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                          |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>163X</b>  |                          |  |  |
| 19a. DATE OF OPERATION   |                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                          | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |                          | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>  |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                          | 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-16</b> , 19 <b>68</b> , to <b>4-24</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-24</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |                          |  |  |
| 22b. SIGNATURE <b>E.R. Sandyn</b>  |                          | 22c. DATE SIGNED <b>4-24</b>   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>E.R. Sandyn</b>  |                          | 22e. ADDRESS <b>GREATER BALTO. MED. CENTRE</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                          | 23b. DATE <b>4/27/68</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>   |                          | 23d. LOCATION (City or Town) (County) (State) <b>BALTO. Md.</b>  |  |
| 24. FUNERAL DIRECTOR <b>Connelly Funeral Home</b>  |                          | 25a. REC'D BY REGISTRAR <b>APR 29 1968</b>   |  |
| ADDRESS <b>300 Macduie</b>   |                          | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |   |  |   |  |  |
|---|--|--|--|---|--|---|--|---|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |   |  |   |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br><b>Blanche</b>  |  | Middle<br><b>M.</b>   |  | Last<br><b>Lingg</b>  |  | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>11</b> Year <b>1968</b>  |  |   | 2b. HOUR<br><b>8:40</b> A.M.                       |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Cau.</b>   |  | 5. DATE OF BIRTH<br><b>May 10, 1894</b>   |  |   | 6. AGE (In years<br>lost birthday)<br><b>73</b> YRS. |   | IF UNDER 1 YEAR<br>MONTHS <b>73</b> DAYS <b>73</b>     |   | IF UNDER 24 HRS.<br>HOURS <b>73</b> MIN. <b>73</b> |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Balto. Co. Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Pikesville</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>19 Old Court Rd.</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Presser</b>                    |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Uniform</b> |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  | 13e. STREET AND NUMBER<br><b>3317 Hayward Ave.</b>                      |  |   |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Richard Whitcomb</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Ruth Fuller</b>  |  |   |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>216-01-1798</b>  |  | 17. INFORMANT Address<br><b>Mr. James H. Lingg, 3317 Hayward Ave. Balto. Md.</b>  |  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of liver</b><br><b>1977.8</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1561</b> DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 years</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>1561</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                            |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1958</b> , to <b>Apr. 11, 1968</b> , that (I) (we) lost saw the deceased alive on <b>April 8, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |  |  |  |   |  |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>R. Donald Jandorf</b> DEGREE <b>M.D.</b>   |  |  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4-11-68</b>                                      |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>R. Donald Jandorf, M.D.</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>6077 Harford Road, Balto. Md.</b>  |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/15/1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville, Balto. Co. Md.</b>  |  |   |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>B. Vernon Lemmon</b> ADDRESS<br><b>4611 Park Heights Ave. Balto.</b>   |  |  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 15 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                      |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |                                  |   |  |   |  |   |                                      |  |                                |  |
|---|--|--|----------------------------------|---|--|---|--|---|--------------------------------------|--|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                                  |   |  |   |  |   |                                      |  |                                |  |
| CERTIFICATE OF DEATH  |  |  |                                  |   |  |   |  |   |                                      |  |                                |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Rose Lombardo  |  |  |                                  |   | 2a. DATE OF DEATH<br>Month Day Year<br>4-29-68                                       |   |  | 2b. HOUR<br>M                                 |                                      |  |                                |  |
| 3. SEX<br>Female  |  | 4. RACE<br>W   |                                  | 5. DATE OF BIRTH<br>11-21-1886  |  |   | 6. AGE (In years<br>last birthday)<br>81 YRS.                        |   | IF UNDER 1 YEAR<br>MONTHS DAYS       |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |                                      |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Shangri-La Nursing Home |                                  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Housewife |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Balto.  |                                  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |  | 13e. STREET AND NUMBER<br>4903 St. Gemma Road |                                      |  |                                |  |
| 14. FATHER'S NAME First Middle Last<br>Joseph Dantoni   |  |  |                                  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Lucy Poligardo                         |   |  |   |                                      |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>None |   | 17. INFORMANT<br>1540 Forest Park Ave.<br>Mr. Vincent Lombardo, Balto., Md. 21207    |   |  |   |                                      |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Uremia</u><br><u>4109</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic CVD</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 months</u><br><u>3 months</u><br><u>10 years</u> |  |  |                                  |   |  |   |  |   |                                      |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>4201 Diabetes Mellitus</u>   |  |  |                                  |   |  |   |  |   |                                      |  |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |                                      |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |                                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |                                      |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                            |                                  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |   |  |   |                                      |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/15</u> , 19 <u>66</u> , to <u>April 29</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>April 23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) ( <del>did</del> ) (did not) view the body after death.   |  |  |                                  |   |  |   |  |   |                                      |  |                                |  |
| 22b. SIGNATURE<br><u>Kennard Yaffe MD</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |                                  |   | 22c. DATE SIGNED<br><u>4/30/68</u>   |   |  |   |                                      |  |                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>KENNARD YAFFE</u>  |  |  |                                  |   | 22e. ADDRESS<br><u>5501 Forest Park Ave</u>  |   |  |   |                                      |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE<br><u>5-2-68</u>   |                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>New Cathedral Cemetery</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Balto.</u> <u>Md.</u>                               |  |   |                                      |  |                                |  |
| 24. FUNERAL DIRECTOR<br><u>Witzke Funeral Directors, Balto., Md. 21229</u>  |  |  |                                  |   | 25a. REC'D BY REGISTRAR<br>DATE <u>MAY 1 1968</u>                                    |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                   |   |                                      |  |                                |  |

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Abstract

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05294

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05296

|   |                      |  |  |   |   |   |  |  |  |
|---|----------------------|--|--|---|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>JOHN OLIVER LONG</b>   |                      |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>4-21-68</b> |   |   | 2b. HOUR <b>10:00</b>   |  |  |  |
| 3. SEX <b>Male</b>  | 4. RACE <b>White</b> | 5. DATE OF BIRTH <b>July 11, 1894</b>  | 6. AGE (In years last birthday) <b>73</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>  | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>        | 2c. DATE PRONOUNCED DEAD<br>Month <b>April</b> Day <b>22</b> Year <b>1968</b> |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>Baltimore</b>   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Dundalk</b>  |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>2902 Liberty Parkway</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City Health Dept.</b>                            |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |                      |  | 13b. COUNTY <b>Baltimore</b>   |   | 13c. CITY OR TOWN <b>Dundalk</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME First <b>?</b> Middle <b>?</b> Last <b>?</b>  |                      |  | 15. MOTHER'S MAIDEN NAME First <b>?</b> Middle <b>?</b> Last <b>?</b>  |   |   | 13e. STREET AND NUMBER <b>2902 Liberty Parkway</b>                            |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>   |                      |  | 16b. SOCIAL SECURITY NO. <b>215-16-9698A</b>   |   | 17. INFORMANT <b>Alfred Long</b>  |   |  | ADDRESS <b>8504 Kavanaugh Rd., 21222</b>           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4129</b> IMMEDIATE CAUSE (a) <b>A-S-C-V-Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>4221</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4221</b>   |                      |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |                      |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION <b>4-22-68</b>   |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Time</b>   |   |   |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      |  | 21b. TIME OF INJURY Month, Day, Year <b>1968</b><br>HOUR A.M. <b>19</b> P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                      |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |   | 21f. LOCATION Street or R.F.D. No. <b>6800 Morningside Rd.</b>                          |   | City or Town <b>Baltimore</b> County <b>Md.</b> State <b>Md.</b>                             |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                      |  |  |   |   |   |  |  |  |
| ACTUAL SIGNATURE <b>Melvin B. Davis</b>   |                      |  | M.D. <b>Melvin B. Davis, M. D.</b>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | 22b. DATE SIGNED <b>4/23/68</b>  |  |  |
| EXAMINER'S NAME (Type) <b>Melvin B. Davis, M. D.</b>  |                      |  | ADDRESS (Street, city, town, or county) <b>6800 Morningside Rd. 21222</b>  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                             |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                      | 23b. DATE <b>4/25/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>  |   |   | 23d. LOCATION (City or Town) <b>Baltimore</b> (County) <b>Md.</b> (State) <b>Md.</b>         |  |  |
| 24. FUNERAL DIRECTOR <b>Thelma A. Hoffman</b>   |                      |  |  | ADDRESS <b>3218 Hudson Street</b>   |   | 25a. REC'D BY REGISTRAR <b>APR 26 1968</b>                                    |  | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b> |  |

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UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

January 1, 1900

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 29th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Your obedient servant,

John D. Smith

Secretary

United States Department of Agriculture

Washington, D. C.

Very truly yours,

John D. Smith

Secretary

United States Department of Agriculture

Washington, D. C.

Very truly yours,

John D. Smith

Secretary

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FMS-100. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |   |   |  |  |
|---|--|--|--|--|--|--|--|---|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or Print)   |  |  | First Middle Last  |  |  | 2a. DATE KNOWN OF DEATH  |  |   | 2b. HOUR  |  |  |
| Grace   |  |  | Alice  |  |  | Lonsdale   |  |   | Month Day Year  |  |  |
| 3. SEX  |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |   | 6. AGE (In years last birthday)                                     |  |  |
| F   |  |  | W  |  |  | 11/4/32  |  |   | 35 YRS.   |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED   |  |   | 9. COUNTY OF DEATH  |  |  |
| Penna.  |  |  | U.S.A.   |  |  | NEVER MARRIED  |  |   | Baltimore Md.   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of life even if retired.) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| Balto. County   |  |  | D.O.A. St. Joseph Hosp.  |  |  | Housewife  |  |   | Home  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |   | 13d. INSIDE CITY LIMITS?  |  |  |
| Md.   |  |  | Balto.   |  |  | Lutherville  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                   |  |   | 16b. SOCIAL SECURITY NO.  |  |  |
| First Middle Last   |  |  | First Middle Last  |  |  | No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  |   | 212-28-3667   |  |  |
| Willard L. Bennett  |  |  | Eudora Lewis   |  |  | 17. INFORMANT  |  |   | ADDRESS   |  |  |
|   |  |  |  |  |  | Mr. Richard T. Lonsdale, Same as # 13  |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |   |   |  |  |
| IMMEDIATE CAUSE (a) Fracture of Neck and Severance  |  |  |  |  |  |  |  |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |   |   |  |  |
| (b) Of Spinal Cord at Brain Stem  |  |  |  |  |  |  |  |   |   | Sudden                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |   |   |  |  |
| (c)   |  |  |  |  |  |  |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |   |  |  |
| 8169  |  |  |  |  |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |  |  | 20. AUTOPSY?  |   |  |  |
|   |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>  |  |  |  | 21b. TIME OF INJURY Month, Day, Year   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |  |
| CAUSE OF DEATH  |  |  |  | P.M. April 22 1968   |  |  |  | Car Ran off Road Struck a Tree  |   |  |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |  |  | Street   |  |  |  | Lanrettsville Pike 1300 Ft North Blenheim Md.                                   |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Sudden |  |  |  |  |  |  |  |   |   |  |  |
| ACTUAL SIGNATURE  |  |  |  | CHIEF MEDICAL EXAMINER   |  |  |  | 22b. DATE SIGNED  |   |  |  |
| EXAMINER'S NAME (Type)  |  |  |  | ASSISTANT MEDICAL EXAMINER   |  |  |  | 4/22/68   |   |  |  |
| Charles F. O'Donnell, M.D.  |  |  |  | DEPUTY MEDICAL EXAMINER  |  |  |  |   |   |  |  |
| ADDRESS (Street, city, town, or county)   |  |  |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)                                    |  |  |  | 23b. DATE   |   |  |  |
|   |  |  |  | Burial   |  |  |  | 4-25-1968   |   |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  | 23d. LOCATION (City or Town) (County) (State)                                |  |  |  | 24. FUNERAL DIRECTOR  |   |  |  |
| Druid Ridge Cemetery  |  |  |  | Pikesville, Md.  |  |  |  | Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204                   |   |  |  |
| 25a. REC'D BY REGISTRAR   |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  | DATE  |   |  |  |
| APR 25 1968   |  |  |  | Charles Judge  |  |  |  |   |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-19-64  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |  |  |   |  |  |  |   |
|---|--|---|---|---|--|--|---|--|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |  |  |   |  |  |  |   |
| CERTIFICATE OF DEATH  |  |   |   |   |  |  |   |  |  |  |   |
| 1. DECEASED-NAME<br>(Type or print) <b>George E. Mack</b>   |  |   |   |   |  | 2a. DATE OF DEATH<br>Month <b>April</b> , Day <b>16</b> , Year <b>1968</b>   |   |  | 2b. HOUR<br><b>6:30 A.M.</b>                                 |  |   |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br><b>May 30, 1894</b>   |  |  | 6. AGE (in years lost birthday)<br><b>73</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>               |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN <b></b> |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |   |  |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Halethorpe</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>3723 First Ave</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Crain Operator</b>                               |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Western Electric</b> |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Halethorpe</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>5723 First Ave</b>              |  |   |
| 14. FATHER'S NAME<br>First <b>Gustav</b> Middle <b>MAK</b> Last <b></b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>First <b>MARY</b> Middle <b>Schwartz</b> Last <b></b>   |  |  |   |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>Yes</b>   |  | (If yes give war or dates of service)<br><b>WWI</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>215-10-4196</b>  |  | 17. INFORMANT<br>Address <b>Agnes A. Mack 5723 First Ave</b>   |   |  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Rectum</b><br><b>1541</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 Yes</b> |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>154X</b>   |  |   |   |   |  |  |   |  |  |  |   |
| 19a. DATE OF OPERATION<br><b>4-20-66</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma</b>                              |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b><br>P.M. <b></b> |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                      |   | 21f. LOCATION<br>Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>   |  |  |   |  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Apr. 20, 1966</b> , to <b>Apr. 16, 1968</b> , that (I) (we) last saw the deceased alive on <b>Apr. 15, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |   |   |   |  |  |   |  |  |  |   |
| 22b. SIGNATURE<br><b>A. Bradley Daugharty MD</b>  |  |   |   |   |  | DEGREE <b></b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4-16-68</b>                                   |  |  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. A. Bradley Daugharty</b>   |  |   |   |   |  | 22e. ADDRESS<br><b>1264 Francis Ave.</b>   |   |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/19/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Louisa Park Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b>   |   |  |  |  |   |
| 24. FUNERAL DIRECTOR<br><b>Ambrose, Inc. 1328 Sulphur Spring Rd</b>   |  |   |   |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>Apr 19 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Frank J. Judge</b>                  |  |  |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| 1. DECEASED-NAME (Type or print)  |  |  |  |  | First Middle Last  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  | 2b. HOUR   |  |  |  |  |                            |  |  |  |  |
| James   |  |  |  |  | E. Mack  |  |  |  |  | Month Day Year   |  |  |  |  | April 8 68   |  |  |  |  |                            |  |  |  |  |
| 3. SEX  |  |  |  |  | 4. RACE  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  | 6. AGE (In years lost birthday)  |  |  |  |  |                            |  |  |  |  |
| Male  |  |  |  |  | Negro  |  |  |  |  | 1893   |  |  |  |  | 75 YRS.  |  |  |  |  |                            |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |                            |  |  |  |  |
| Maryland  |  |  |  |  | U.S.A.   |  |  |  |  |  |  |  |  |  | Baltimore Md.  |  |  |  |  |                            |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                            |  |  |  |  |
| Reisterstown  |  |  |  |  | Bent Nursing Home  |  |  |  |  | Laborer  |  |  |  |  | Unknown  |  |  |  |  |                            |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |                            |  |  |  |  |
| Maryland  |  |  |  |  | Baltimore  |  |  |  |  | Glyndon  |  |  |  |  | 85 Railroad Avenue   |  |  |  |  |                            |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| First Middle Last   |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| Unknown   |  |  |  |  | Unknown  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT  |  |  |  |  | Address  |  |  |  |  |                            |  |  |  |  |
| Unknown   |  |  |  |  | 219-16-5601  |  |  |  |  | Bent Nursing Home Records  |  |  |  |  | Reisterstown Md.   |  |  |  |  |                            |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |                            |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| IMMEDIATE CAUSE (a) Terminal Pneumonia  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 24-48 hrs.   |  |  |  |  |                            |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| (b) Malnutrition, Epilepsy, Arteriosclerosis C.V. Dis.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | years  |  |  |  |  |                            |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| (c)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| 286.5   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |                            |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| 22a. I certify that (H) (this hospital) attended the deceased from 2/13, 1967, to 4/8, 1968, that (H) (we) last saw the deceased alive on 4/8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |                            |  |  |  |  |
| Martin E. Strobel, MD   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 4/8/68   |  |  |  |  |                            |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |                            |  |  |  |  |
| MARTIN E. STROBEL   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | REISTERSTOWN MD.   |  |  |  |  |                            |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |                            |  |  |  |  |
| Burial  |  |  |  |  | April 10, 1968   |  |  |  |  | Mt. Auburn Cemetery Baltimore, Maryland  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |  |
| H. J. Edhardt   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | DATE   |  |  |  |  | APR 10 1968                |  |  |  |  |
| Owings Mills, Md.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Charles Judge              |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05298

05300

|  |                  |   |   |  |  |
|--|------------------|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br>First James Middle Simon Last MacKenzie   |                  |   | 2a. DATE OF DEATH<br>Month April Day 24, Year 1968  |  | 2b. HOUR<br>M  |
| 3. SEX<br>Male   | 4. RACE<br>White | 5. DATE OF BIRTH<br>Jan. 10, 1903   |   | 6. AGE (In years<br>lost birthday)<br>65 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS   |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Scotland   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.                                    |
| 10. CITY OR TOWN OF DEATH<br>Towson  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Chesapeake Manor Nursing |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Supervisor |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland   |                  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Timonium   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          | 13e. STREET AND NUMBER<br>2413 Springlake Dr. 21093                    |
| 14. FATHER'S NAME<br>First John Middle L. Last MacKenzie   |                  | 15. MOTHER'S MAIDEN NAME<br>First Elizabeth Middle Cormie Last  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br>No  |                  | 16b. SOCIAL SECURITY NO.<br>012-10-7379   | 17. INFORMANT<br>Address<br>Mrs. Helen U. MacKenzie 2413 Springlake Dr.   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br><u>4309</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral hydrocephalus</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rupture arteriovenous aneurysm</u> |                  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 month<br>3 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><u>330x</u>  |                  |   |   |  |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |                  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)                          |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |                  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                             |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August 24, 1965</u> , to <u>April 24, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 20, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                  |   |   |  |  |
| 22b. SIGNATURE<br><u>Donald O. Wood</u>  |                  |   |   | 22c. DATE SIGNED<br>4-26-68  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>DONALD O. WOOD, M.D.   |                  |   |   | 22e. ADDRESS<br>York Road and Greenmeadow Drive<br>Timonium, Maryland 21093                              |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |                  | 23b. DATE<br>4/27/68  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Cemetery  |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson 1050 York Rd. 21204   |                  | 23d. LOCATION (City or Town) (County) (State)<br>Cockeysville, Balto. Md.                                   |   | 25a. REC'D BY REGISTRAR<br>DATE APR 29 1968  |  |
|  |                  |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 05293   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                         |  |   |  | 05301   |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Frank Macneill  |  |   |  |   |  | 2a. DATE OF DEATH Month Day Year<br>APRIL 23 1968   |  | 2b. HOUR<br>7:55 PM  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH<br>Aug. 5, 1895  |  | 6. AGE (In years last birthday)<br>72 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S. A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Balto. Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Summit Nursing Home |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>704 Cooks Lane, Balto., Md.      |  |
| 14. FATHER'S NAME First Middle Last<br>Frank Macneill   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Mary Bell Macneill  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) No   |  | 16b. SOCIAL SECURITY NO.<br>081-09-8018-A   |  | 17. INFORMANT Address<br>704 Cooks Lane Mrs. Frank Macneill, Balto., Md. 21229  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatous</u><br>1619 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Larynx</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Cardio Vasc. Disease</u> |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br>161X  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 17, 1968</u> , to <u>Apr. 23, 1968</u> , that (I) (we) last saw the deceased alive on <u>Apr. 23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>HARRY Knipp</u>  |  | DEGREE<br>Dr.   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br>4-24-68   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Dr. HARRY Knipp   |  | 22e. ADDRESS<br>4116 Edmondson Ave 21229  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>4-27-68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Laurel Memorial Park  |  | 23d. LOCATION (City or Town) (County) (State)<br>Pomona, N. J.                                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Witzke Funeral Directors, Balto., Md. 21229   |  | ADDRESS<br>4101 Edmondson Avenue  |  | 25a. REC'D BY REGISTRAR<br>DATE APR 25 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |  |

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*J. L. Thompson*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05300

05302

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>George W. MALKemus</i>  |  |   | 2a. DATE OF DEATH<br>Month <i>April</i> Day <i>15</i> Year <i>1968</i>         |   |  | 2b. HOUR<br><i>8:00 PM</i>  |  |  |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br><i>Sept. 4<sup>th</sup> 1889</i>  |  | 6. AGE (In years<br>lost birthday) <i>78</i> YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN.               |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <i>N. Y.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>America</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Baltimore County, Balto. Md.</i>                                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><i>Summit Nursing Home</i> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><i>Retired</i>  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><i>U.S. Rubber Co.</i>                                  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE <i>Maryland</i>   |  | 13b. COUNTY<br><i>Balto.</i>  |  | 13c. CITY OR TOWN<br><i>Balto.</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>15 Mallowhill Rd.</i>                                 |  |
| 14. FATHER'S NAME First <i>Andrew</i> Middle <i>Mallemus</i> Last <i>MARY</i>  |  |   | 15. MOTHER'S MAIDEN NAME First <i>MARY</i> Middle <i>MARY</i> Last <i>MARY</i> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>216-01-2702</i>  |  | 17. INFORMANT<br><i>Mrs. George W. Malkemus, Balto., Md. 21229</i>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>342X Intestinal Obstruction - recurrent</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Parkinson's disease - intestinal</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>altery + cardiac arrest</i>  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>24 hrs.</i><br><i>3 yrs.</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><i>350X</i>  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1961</i> to <i>Apr 15, 1968</i> , that (I) (we) last<br>saw the deceased alive on <i>Sept 10, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Harry B. Scott M.D.</i>   |  | 22c. DATE SIGNED<br><i>4/15/68</i>  |  | 22d. PHYSICIAN'S<br>NAME (Type) <i>HARRY B. SCOTT M.D.</i>  |  |   |  | 22e. ADDRESS<br><i>721 Medical Arts Bldg.</i>                                      |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><i>Burial</i>  |  | 23b. DATE<br><i>4-18-68</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Rual (Poughkeepsie, N. Y.)</i>   |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Witzke Funeral Directors, Balto., Md. 21229</i>   |  | 25a. REC'D BY REGISTRAR<br><i>APR 17 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>James J. Judge</i>   |  |   |  |  |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |                         |   |  |   |   |   |   |   |   |  |
|--|-------------------------|---|--|---|---|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or Print)<br><b>THOMAS Lee MALONEY</b>   |                         |   | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> Month <b>4</b> Day <b>12</b> Year <b>1968</b> |   |   | 2b. HOUR<br><b>12:45</b><br>P M   |   |   |   |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br><b>Feb. 16, 1920</b>  | 6. AGE (in years last birthday)<br><b>47.8</b> RS.   | IF UNDER 1 YEAR<br>MONTHS<br><b>4</b> DAYS<br><b>12</b>   | IF UNDER 24 HRS.<br>HOURS<br><b>12</b> MIN.<br><b>45</b>  | 2c. DATE PRONOUNCED DEAD<br>Month <b>April</b> Day <b>12</b> Year <b>1968</b>                   |   |   | 2d. HOUR<br><b>12:45</b><br>P M                           |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Ohio</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph's</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)<br><b>Procurement Mgr.</b> |   |   | 12b. OF INDUSTRY<br><b>Crippled Child</b>   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Towson</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>928 Beaverbank Circle</b>                              |   |  |
| 14. FATHER'S NAME<br>First <b>Deforest</b> Middle <b>Maloney</b> Last <b>Maloney</b>   |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Margaret</b> Middle <b>Shull</b> Last <b>Shull</b>   |   |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown)<br><b>Yes</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(If yes, give year of service)<br><b>294-03-2838</b>                    |  | 17. INFORMANT<br><b>Joan E. Maloney</b>   |   |   |   | ADDRESS<br><b>928 Beaverbank Circle, Towson</b>                                     |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4129</b><br><b>4221</b>   |                         |   |  |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><b>Fracture of Clavicle and Pulmonary Emphysema</b>   |                         |   |  |   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/><br>CAUSE OF DEATH   |                         |   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>UNKN. P.M. <b>4/12 19 68</b>                            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Subj. fell off ladder</b>   |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>home</b>         |  |   | 21f. LOCATION Street or R.F.D. No.<br><b>Towson</b>   |   | City or Town<br><b>Baltimore, Md.</b>                                       |   | County<br><b>Baltimore, Md.</b>                           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |   |  |   |   |   |   |   |   |  |
| ACTUAL SIGNATURE<br><b>Werner U. Spitz, M.D.</b>   |                         |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |   | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                                  |   |   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>          |  |
| EXAMINER'S NAME (Type)   |                         |   | ADDRESS (Street, city, town, or county)  |   |   | 22b. DATE SIGNED<br><b>4/13/68</b>  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 23b. DATE<br><b>April 16, 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. National Cemetery</b>   |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>John Burns' Sons, Towson, Maryland</b>  |                         |   |  | ADDRESS   |   | 25a. REC'D BY REGISTRAR<br><b>APR 17 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| 1. DECEASED-NAME<br>(Type or print)  |  |  |  | First   | Middle | Last   | 2a. DATE OF DEATH        |  | 2b. HOUR |                  |       |        |      |
|--|--|--|--|---|--------|--|--------------------------|--|----------|------------------|-------|--------|------|
| Marion   |  |  |  | D.  |        | Malpass  | April 5, 1968            |  | M        |                  |       |        |      |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |        | 6. AGE (In years lost birthday)  |                          | IF UNDER 1 YEAR  |          | IF UNDER 24 HRS. |       |        |      |
| Male   |  | White  |  | 4-10-1898   |        | 69 YRS.  |                          | MONTHS DAYS  |          | HOURS MIN.       |       |        |      |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. COUNTY OF DEATH   |                          |  |          |                  |       |        |      |
| N. Carolina  |  | USA  |  |   |        | Baltimore Md.  |                          |  |          |                  |       |        |      |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |        | 12b. KIND OF BUSINESS OR INDUSTRY  |                          |  |          |                  |       |        |      |
| Baltimore  |  | Summit Nursing Home  |  | Self Employed-Furniture Bus.  |        |  |                          |  |          |                  |       |        |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |        | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                          | 13e. STREET AND NUMBER   |          |                  |       |        |      |
| Maryland   |  | Baltimore  |  | Balto   |        |  |                          | 3807 Beech Avenue  |          |                  |       |        |      |
| 14. FATHER'S NAME  |  |  |  | First   | Middle | Last   | 15. MOTHER'S MAIDEN NAME |  |          |                  | First | Middle | Last |
| Barry Wright Malpass   |  |  |  |   |        |  | Katie Pope               |  |          |                  |       |        |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |        | Address  |                          |  |          |                  |       |        |      |
| NO   |  | 213-03-5505  |  | Hester Malpass  |        | 3807 Beech Avenue  |                          |  |          |                  |       |        |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CV Disease</u><br><u>4129</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4221</u> (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 MOST</u> |  |  |  |   |        |  |                          |  |          |                  |       |        |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Diabetes Mellitus</u>  |  |  |  |   |        |  |                          |  |          |                  |       |        |      |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |        | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                          | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |          |                  |       |        |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |        |  |                          |  |          |                  |       |        |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |        |  |                          |  |          |                  |       |        |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/100</u> , 19 <u>68</u> , to <u>4/5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/4/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |        |  |                          |  |          |                  |       |        |      |
| 22b. SIGNATURE<br><u>Thos. E. Roach</u>  |  | DEGREE   |  | ATTENDING PHYS.   |        | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>       |                          | 22c. DATE SIGNED<br><u>4/5/68</u>                                    |          |                  |       |        |      |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |   |        |  |                          |  |          |                  |       |        |      |
| Thos. E. Roach   |  | 3530 Baito Natl Pk   |  |   |        |  |                          |  |          |                  |       |        |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |        | 23d. LOCATION (City or Town) (County) (State)  |                          |  |          |                  |       |        |      |
| Burial   |  | 4-8-68   |  | Woodlawn Cemetery   |        | Baltimore, Maryland  |                          |  |          |                  |       |        |      |
| 24. FUNERAL DIRECTOR   |  |  |  | ADDRESS   |        | 25a. REC'D BY REGISTRAR  |                          | 25b. REGISTRAR'S SIGNATURE   |          |                  |       |        |      |
| Ellsworth Armacost   |  |  |  | 4600 Liberty Hgts, Avenue   |        | APR 9 1968   |                          | J. Charles Judge   |          |                  |       |        |      |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |                          |  |   |  |
|--|--|---|--|---|--|---|--|--------------------------|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)  |  | First   |  | Middle  |  | Last  |  | 2a. DATE OF DEATH        |  | 2b. HOUR  |  |
| LENA   |  | -   |  | MANNACAPPELLI   |  | April   |  | Month 16 Day 1968        |  | 8:45 PM   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)  |  | IF UNDER 1 YEAR          |  | IF UNDER 24 HRS.                                |  |
| FEMALE   |  | WHITE   |  | Aug. 3, 1890  |  | 52 77   |  | MONTHS DAYS              |  | HOURS MIN.                                      |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                          |  | Md.   |  |
| Italy  |  | USA Italy   |  |   |  | Baltimore   |  |                          |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |                          |  |   |  |
| Towson   |  | St. Joseph Hospital   |  | Tailor Shop   |  |   |  |                          |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |   |  |
| Maryland   |  | Baltimore   |  | Baltimore   |  |   |  | 8005 High Point Road     |  |   |  |
| 14. FATHER'S NAME  |  | First   |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME |  | First Middle Last                               |  |
| Phillip  |  | Pusateri  |  |   |  |   |  | Rosaria                  |  | Livolsi   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, (unknown)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | Address   |  |                          |  |   |  |
| No   |  | 215-09-1221   |  | Mrs. Josephine Anzalone   |  | 1738 Amuskai Rd. #34  |  |                          |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pulmonary Edema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |   |  |   |  |                          |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |                          |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |                          |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |                          |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |                          |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 30</u> , 19 <u>68</u> , to <u>April 16</u> , 19 <u>68</u> , that (I) (we) last<br>saw the deceased alive on <u>April 16</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |                          |  |   |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED  |  | 22d. PHYSICIAN'S<br>NAME (Type)   |  | 22e. ADDRESS  |  |                          |  |   |  |
| Yusup Oh, M.D.   |  | 4/16/68   |  | Yusup Oh, M.D.  |  | 7620 York Rd., Towson, Md. 21204  |  |                          |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |                          |  |   |  |
| Burial   |  | 4/20/68.  |  | Holy Redeemer Cemetery  |  | Baltimore, Md.  |  |                          |  |   |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                          |  |   |  |
| Leonard J. Ruck, Inc.  |  | Ba lto. Md. 21214   |  | APR 18 1968   |  | John J. Gage  |  |                          |  |   |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
10M REV. 1-68

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                  |  |   |   |   |   |  |   |  |
|---|------------------|--|---|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(Type or Print)<br>Stanley J. Maranovich  |                  |  | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br>Apr. 6, 19 68          |   |   | 2b. HOUR<br>M   |  |   |  |
| 3. SEX<br>Male  | 4. RACE<br>White | 5. DATE OF BIRTH<br>Aug. 12, 1902  | 6. AGE (In years last birthday)<br>65 YRS.                          | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS<br>HOURS MIN.   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>April 8, 19 68                                    |  |   | 2d. HOUR<br>M                                |
| 7a. BIRTHPLACE (State or foreign country)<br>Pennsylvania   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |   | 8. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Edgemere   |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>3100 Riverdrive Road |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br>Turn Foreman - Bethlehem Steel Co |   |  | 12b. KIND OF BUSINESS OR INDUSTRY             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |                  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Edgemere   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>3100 Riverdrive Rd. |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Dominic Maranovich  |                  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Louise Grudzinski  |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) No                        |  |   |  |
| 16b. SOCIAL SECURITY NO.<br>213-07-6758   |                  |  | 17. INFORMANT (Wife)<br>Mrs. Elvera Maranovich, 3100 Riverdrive Rd. |   |   | ADDRESS Edgemere, Md.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>HCVD</u><br>(b) <u>4109</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>4201</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |                  |  |   |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br>19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                         |   | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |  | County  | State  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/> 105 Main Street<br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b. DATE SIGNED 4/6/68<br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>M.D. ADDRESS (Street, city, town, or county) Dundalk, Md. |                  |  |   |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                  | 23b. DATE<br>4/10/68   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart of Mary  |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.                                 |  |   |  |
| 24. FUNERAL DIRECTOR<br>John J. Duda, 7922 Wise Ave. Dundalk, Md.   |                  |  |   | 25a. REC'D BY REGISTRAR<br>DATE APR 15 1968   |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |   |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| 1. DECEASED-NAME<br>(Type or print)  |  | First  | Middle | Last   | 2a. DATE OF DEATH   |  |  | 2b. HOUR                          |   |  |  |
|--|--|--|--------|--|---|--|--|-----------------------------------|---|--|--|
| William Braddy Mason   |  |  |        |  | Month   | Day  | Year   | 3:30 P.M.                         |   |  |  |
| 3. SEX   |  | 4. RACE  |        | 5. DATE OF BIRTH   |   |  | 6. AGE (In years last birthday)                                      |                                   | IF UNDER 1 YEAR<br>MONTHS DAYS                              |  |  |
| male   |  | negro  |        | May 10 1900  |   |  | 67 YRS.  |                                   |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED<br>WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |                                   |   |  |  |
| Worcester  |  |  |        |  |   | Baltimore CO. Md.  |  |                                   |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |  |
| Garrison Md.   |  | Fowler's Conv. Home  |        |  | Dentist   |  |  | Professional                      |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |        | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER            |   |  |  |
| 3501 Foxcliff Ct   |  | Baltimore  |        | Baltimore  |   |  |  | 3501 Foxcliff Court               |   |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |        |  |   |  |  |                                   |   |  |  |
| First Middle Last  |  | First Middle Last  |        |  |   |  |  |                                   |   |  |  |
| William B. Mason   |  | Lucy J. Martin   |        |  |   |  |  |                                   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no) or (unknown)   |  | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT  |   | Address  |  |                                   |   |  |  |
| (If yes give war or dates of service)  |  | 214-40-6526 A  |        | - Frederick B. Brown   |   | 5213 12th St. N.E. Wash.D.C.   |  |                                   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer - Prostate</u><br><u>185X</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>metastasis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____ |  |  |        |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 YR</u> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>177X</u>   |  |  |        |  |   |  |  |                                   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |        |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |  |                                   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |                                   | County State  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 24</u> , 19 <u>67</u> , to <u>April 17</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>April 10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |  |        |  |   |  |  |                                   |   |  |  |
| 22b. SIGNATURE<br><u>Leon G. Sheer MD</u>  |  | 22c. DATE SIGNED<br><u>14 April 1968</u>                                     |        | 22e. ADDRESS<br><u>6715 PARK HEIGHTS AVE.</u>  |   |  |  |                                   |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>LEON G. SHEER, MD</u>   |  |  |        |  |   |  |  |                                   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |   |  | 23d. LOCATION (City or Town) (County) (State)                        |                                   |   |  |  |
| Burial   |  | 4/19/68  |        | Lincoln Memorial Cemetery  |   |  | Sutland Maryland   |                                   |   |  |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |        |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |                                   |   |  |  |
| Nutter Funeral Home - 3035 W. North Ave.   |  |  |        |  | APR 22 1968   |  | <u>John J. Judge</u>   |                                   |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05306

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05308

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED-NAME<br>(Type or print) <b>ANNIE KATHERINE MATTINGLY</b>  |   |   | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>21</b> Year <b>1968</b>            |   | 2b. HOUR<br><b>7:30 A.M.</b>                          |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>                       | 5. DATE OF BIRTH<br><b>July 5, 1885</b>   |   | 6. AGE (In years last birthday)<br><b>82</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.             |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Arbutus</b>   |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>4720 Gateway Terrace</b>   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b> |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Arbutus</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             | 13e. STREET AND NUMBER<br><b>4720 Gateway Terrace</b> |
| 14. FATHER'S NAME First Middle Last<br><b>William F. Keys</b>   |   |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Agnes Brautigam</b>              |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)   |   | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT Address<br><b>Mr. Carl G. Mattingly, 4720 Gateway Terrace</b> 21227 |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive Myocardial Infarction</b><br><b>4109</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>   |   |   |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                   |   |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   | 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)    |   |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1967</b> , to <b>4.21. 1968</b> , that (I) (we) last saw the deceased alive on <b>4.21. 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |   |   |
| 22b. SIGNATURE<br><b>Stanley Ankudas</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |   |   |   | 22c. DATE SIGNED<br><b>4.22.68</b>  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Stanley Ankudas</b>  |   | 22e. ADDRESS<br><b>1101 Maiden Choice Lane, Balto., Md.</b>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE<br><b>4-24-1968</b>                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cem.</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>       |   |   |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>   |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 23 1968</b>                                | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1/68

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|   |         |  |                  |   |                                     |  |  |  |
|---|---------|--|------------------|---|-------------------------------------|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |         | First  | Middle           | Last  | 2a. DATE OF DEATH<br>Month Day Year |  | 2b. HOUR P                               |  |
| FRANK   |         | JAMES  | McMAHON          | APRIL 28, 1968  |                                     | 10:20  |  |  |
| 3. SEX  | 4. RACE |  | 5. DATE OF BIRTH |   | 6. AGE (In years lost birthday)     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |  |
| MALE  | WHITE   |  | JANUARY 31, 1909 |   | 59 YRS.                             |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. COUNTY OF DEATH   |  | Md.  |
| VIRGINIA  |         | U.S.A.   |                  | BALTIMORE   |                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                     | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| TOWSON  |         | ST. JOSEPH HOSPITAL  |                  | SUPERVISOR  |                                     | BETH. STEEL  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |                  | 13c. CITY OR TOWN   |                                     | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                       |
| MARYLAND  |         | BALTIMORE  |                  | DUNDALK   |                                     | XX   |  | 3311 DUNDALK AVE. #21222                     |
| 14. FATHER'S NAME   |         | First  | Middle           | Last  | 15. MOTHER'S MAIDEN NAME            |  | First                                    | Middle Last                                  |
| FRANK J. McMAHON, Sr.   |         |  |                  |   | EUGENIA JACKSON                     |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |         | 16b. SOCIAL SECURITY NO.   |                  | 17. INFORMANT   |                                     | Address  |  |  |
| NO  |         | 213/09/3758  |                  | MILDRED M. McMAHON--AS IN (# 13 a-e)  |                                     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ |         |  |                  |   |                                     |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>4201   |         |  |                  |   |                                     |  |  |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                     |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  | 21f. LOCATION Street or R.F.D. No.  |                                     | City or Town   |  | County State                                 |
|   |         |  |                  |   |                                     |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>APRIL 5, 1968</u> , to <u>APRIL 28, 1968</u> , that (1) (we) lost saw the deceased alive on <u>APRIL 28, 1968</u> , and that in (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.      |         |  |                  |   |                                     |  |  |  |
| 22b. SIGNATURE  |         | 22c. DATE SIGNED   |                  | 22d. PHYSICIAN'S NAME (Type)  |                                     | 22e. ADDRESS   |  |  |
|   |         | APRIL 28, 1968   |                  | ISMAEL JAMORA, M.D.   |                                     | 7620 YORK ROAD TOWSON, MD. #21204  |  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY  |                                     | 23d. LOCATION (City or Town) (County) (State)  |  |  |
| BURIAL  |         | 5/2/1968   |                  | OAK LAWN  |                                     | BALTO., CO. MARYLAND   |  |  |
| 24. FUNERAL DIRECTOR  |         | 25a. REC'D BY REGISTRAR  |                  | 25b. REGISTRAR'S SIGNATURE  |                                     |  |  |  |
| W. BROOKS BRADLEY DUNDALK, MD.  |         | DATE MAY 2 1968  |                  |   |                                     |  |  |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MD-17. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |                  |   |  |  |  |   |  |   |  |   |           |   |                        |                        |  |
|---|------------------|---|--|--|--|---|--|---|--|---|-----------|---|------------------------|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |                  |   |  |  |  |   |  |   |  |   |           |   |                        |                        |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                  |   |  |  |  |   |  |   |  |   |           |   |                        |                        |  |
| 1. DECEASED-NAME<br>(Type or Print)   |                  | First<br>HARRIETTE  |  | Middle<br>ELIZABETH  |  | Last<br>MC MAHON  |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/>  |  | Month<br>April                              | Day<br>10 | Year<br>1968                                    | 2b. HOUR<br>M<br>11:45 |                        |  |
| 3. SEX<br>Female  | 4. RACE<br>White | 5. DATE OF BIRTH<br>12-8-1910   |  | 6. AGE (In years<br>last birthday)<br>57 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS   |  | IF UNDER 24 HRS<br>HOURS<br>MIN   |  | 2c. DATE PRONOUNCED DEAD<br>Month<br>April  |           | Day<br>10                                       | Year<br>1968           | 2d. HOUR<br>M<br>11:45 |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>MD.   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE   |  |   |  |   |           |   |                        |                        |  |
| 10. CITY OR TOWN OF DEATH<br>Pikesville   |                  |   |  | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital<br>give street address)<br>9 Randall Avenue  |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>HOUSEWIFE   |  |   |           | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>HOME    |                        |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.   |                  |   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Pikesville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER<br>9 Randall Avenue  |           |   |                        |                        |  |
| 14. FATHER'S NAME<br>First<br>William   |                  |   |  | Middle<br>W.   |  | Last<br>HOLLAND   |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Ettie  |  | Middle<br>Mills                             |           | Last<br>Mills                                   |                        |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No   |                  |   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)  |  | 17. INFORMANT<br>MRS. EDWARD KAZMIERKI  |  | ADDRESS<br>SILVER SPRING<br>MD.   |  |   |           |   |                        |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4129<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. }<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                  |   |  |  |  |   |  |   |  |   |           | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                        |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>4221   |                  |   |  |  |  |   |  |   |  |   |           |   |                        |                        |  |
| 19a. DATE OF OPERATION  |                  |   |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |           |   |                        |                        |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                  |   |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M.<br>19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |  |   |  |   |           |   |                        |                        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |  |  |  | 21f. LOCATION Street or R.F.D. No.  |  |   |  | City or Town                                |           | County  |                        | State                  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |   |  |  |  |   |  |   |  |   |           |   |                        |                        |  |
| ACTUAL<br>SIGNATURE<br>EXAMINER'S<br>NAME (Type)  |                  |   |  | Werner U. Spitz, M.D.  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  |   |           | 22b. DATE SIGNED<br>April 10, 1968              |                        |                        |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |                  | 23b. DATE<br>4-18-68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MEADOWRIDGE  |  |   |  | 23d. LOCATION (City or Town)<br>ELK RIDGE   |  | (County)<br>MD.                             |           | (State)   |                        |                        |  |
| 24. FUNERAL DIRECTOR<br>John M. Ly Fox  |                  |   |  | ADDRESS<br>Lansdowne, Md.  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE<br>APR 23 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge |           |   |                        |                        |  |

3055



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05308

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05311

|  |                  |   |   |   |  |   |  |
|--|------------------|---|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>MARGAET ANNE MERRYMAN</b>   |                  |   | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> DAY <b>20</b> Year <b>1968</b> |   |  | 2b. HOUR <b>3 P.</b>  |  |
| 3. SEX <b>F</b>  | 4. RACE <b>W</b> | 5. DATE OF BIRTH <b>4-18-03</b>   | 6. AGE (In years last birthday) <b>65 YRS.</b>  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> | 2c. DATE PRONOUNCED DEAD<br>Month <b>April</b> Day <b>20</b> Year <b>1968</b>   |  |
| 7a. BIRTHPLACE (State or foreign country) <b>MD</b>  |                  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |  | 9. COUNTY OF DEATH <b>BALTIMORE</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH <b>PHOENIX</b>   |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>PHOENIX RD.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>NONE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>M</b>   |                  | 13b. COUNTY <b>BALTO</b>  |   | 13c. CITY OR TOWN <b>PHOENIX</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 14. FATHER'S NAME First <b>—</b> Middle <b>—</b> Last <b>—</b>   |                  | 15. MOTHER'S MAIDEN NAME First <b>—</b> Middle <b>—</b> Last <b>—</b>                           |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>   |  | 16b. SOCIAL SECURITY NO. <b>NONE</b>  |  |
| 17. INFORMANT <b>MARY E. MYERS</b>   |                  | ADDRESS <b>RT 1 BOX 88</b>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b><br><b>4120</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>—</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>443X</b> |                  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                   |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M. <b>19</b>                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                    |   | 21f. LOCATION Street or R.F.D. No. <b>—</b> City or Town <b>—</b> County <b>—</b> State <b>—</b>  |  | 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |
| ACTUAL SIGNATURE <b>William A. Pillsbury</b>   |                  | EXAMINER'S NAME (Type) <b>William A. Pillsbury</b>  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | 22b. DATE SIGNED <b>4-20-68</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |                  | 23b. DATE <b>APR 23/68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>SATER'S</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>BALTO CO</b>   |  |
| 24. FUNERAL DIRECTOR <b>Paul C. Chmowicz</b>   |                  | ADDRESS <b>3615 The Wood Ave</b>  |   | 25a. REC'D BY REGISTRAR <b>APR 23 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>  |  |

64520

WILLIAM E. WILSON, JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |   |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>Margaret Ann Metzdorf</b>   |  |  | 2a. DATE OF DEATH Month Day Year<br><b>April 20 68</b>           |  |  | 2b. HOUR<br><b>4.50PM</b>  |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>8-29-78</b>   |  | 6. AGE (In years lost birthday)<br><b>89</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>wife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>QUEEN ANNES'S</b>  |  | 13c. CITY OR TOWN<br><b>QUEENSTOWN</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>[REDACTED]</b>             |  |
| 14. FATHER'S NAME First Middle Last<br><b>FRANK Benjamin Anthony</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>SARAH Dixon</b> |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-52-8084</b>   |  | 17. INFORMANT<br><b>DAUGHTER</b>   |  | Address<br><b>Mrs. William T. Bookers, 2605 Windsor Ave, Parkville, Md.</b>                  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive pulmonary atelectasis.</b><br><b>450 X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Thromboembolism.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>466 X</b>  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/29/</b> 19 <b>68</b> , to <b>4/20/</b> 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>4/20/</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Cilliani</b>  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>4-21-1968</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Ines Cilliani, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md., 21204</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>April 24, 1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Peter's Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>QUEENSTOWN QUEEN ANNES'S, Md.</b>        |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>James H. Butler Jr. - Butler Bros., Centerville, Md.</b>  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>APR 26 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |  |   |  |

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |   |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
| LAWRENCE   |  |  | MICKEY   |   |  | Month Day Year<br>4 4 68  |  | 10:00 AM   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  |
| MALE   |  | NEGRO  |  | 10/16/22  |  | 45 YRS.   |  | IF UNDER 24 HRS.<br>HOURS MIN  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |  |
| MARYLAND   |  | U.S.A.   |  |   |  | BALTIMORE COUNTY, Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| BALTIMORE  |  |  | VET. ADM. HOSPITAL   |   |  | LABORER   |  | CONSTRUCTION   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| MARYLAND   |  |  |  |   |  | BALTIMORE   |  | 13e. STREET AND NUMBER<br>1028 N. Castle Street  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |   |  |   |  |  |  |
| First Middle Last<br>Robert Mickey   |  |  | First Middle Last<br>Annie Cheatham  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no. or unknown) (If yes give year or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address  |   |  |  |  |
| YES  |  |  | 214 12 15 84   |   | CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1519<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CARCINOMA OF STOMACH<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) 151X<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>BRONCHOPNEUMONIA   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County State   |  |
| 22a. I certify that (a) (this hospital) attended the deceased from 3/15/68, 19, to 4/4/68, 19, that (b) (we) last saw the deceased alive on 4/4/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.                                   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>J. D. Talbert, M.D.  |  |  |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>4/4/68   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>JOHN D. TALBERT, M. D.   |  |  |  |   | 22e. ADDRESS<br>VAH FORT HOWARD, MARYLAND  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |
| BURIAL   |  | 4-8-68   |  | Baltimore National  |  | Baltimore, Maryland   |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |   | 25a. ADDRESS<br>Collick Funeral Home<br>1112 E. Preston St. Baltimore, Md.   |   | 25b. REGISTRAR'S SIGNATURE<br>APR 9 1968 REGISTRAR                       |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                         |  |  |  |   |   |  |  |  |   |  |
|--|--|-------------------------|--|--|--|---|---|--|--|--|---|--|
| CERTIFICATE OF DEATH   |  |                         |  |  |  |   |   |  |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Eleanor J. Miguel</i>   |  |                         | First Middle Last  |  |  | 2a. DATE OF DEATH<br>Month <i>April</i> Day <i>27</i> Year <i>1968</i>  |   |  | 2b. HOUR<br><i>6:15 PM</i>   |  |   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i> |  | 5. DATE OF BIRTH<br><i>July 20, 1898</i> |  |   | 6. AGE (In years last birthday)<br><i>69</i> YRS. |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |  | IF UNDER 24 HRS.<br>HOURS MIN.                        |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |                         | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. COUNTY OF DEATH<br><i>Baltimore County Md.</i>                    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baton Rouge</i>  |  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Summit Nursing Home</i>                             |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>clerk - bank</i>  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>clerk</i>                    |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Maryland</i>   |  |                         | 13b. COUNTY<br><i>Baltimore</i>  |  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>95 Wickham Rd. 21229</i>            |   |  |
| 14. FATHER'S NAME First Middle Last<br><i>William S. Jeffreys</i>  |  |                         | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>Anna L. Coleman</i>   |  |  |   |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |                         | 16b. SOCIAL SECURITY NO.<br><i>212-12-4696</i>   |  |  | 17. INFORMANT Address<br><i>Mr. Eugene L. Kraft 3777 Downydale Dr.</i>  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma of Breast</i><br><i>174X</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                         |  |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 years +</i> |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>170X Acromegaly</i>   |  |                         |  |  |  |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  | 20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |                         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>Jan 1963</i> , to <i>April 27, 1968</i> , that (I) (we) last saw the deceased alive on <i>April 26, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |                         |  |  |  |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>James Nolan</i>   |  |                         | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><i>4/29/68</i>  |   |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>J. J. NOLAN</i>   |  |                         | 22e. ADDRESS<br><i>Baltimore Md 21229</i>  |  |  |   |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                         | 23b. DATE<br><i>4-30-68</i>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cathedral Cem.</i>   |   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Bald. Md.</i>    |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>Forley-Corraney &amp; Co. Baton Rouge, La.</i>  |  |                         |  |  |  | ADDRESS   |   |  | 25a. REC'D BY REGISTRAR<br>DATE <i>MAY 2 1968</i>                    |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles J. Jones</i> |  |

MEDICAL CERTIFICATION

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MINUTE OF MEETING

MINUTE OF MEETING

DATE

TIME

PLACE

MEMBERS

MINUTES

1. OPENING

2. AGENDA

3. REPORT

4. DISCUSSION

5. DECISION

6. CLOSING

7. ADJOURN

8. SIGNATURE

9. DATE

10. TIME

11. PLACE

12. MEMBERS

13. MINUTES

14. REPORT

15. DISCUSSION

16. DECISION

17. CLOSING

18. ADJOURN

19. SIGNATURE

20. DATE

21. TIME

22. PLACE

23. MEMBERS

24. MINUTES

25. REPORT

26. DISCUSSION

27. DECISION

28. CLOSING

29. ADJOURN

30. SIGNATURE

31. DATE

32. TIME

33. PLACE

34. MEMBERS

35. MINUTES

02314

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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |                              |  |         |   |                   |   |          |  |
|--|------------------------------|--|---------|---|-------------------|---|----------|--|
| 1. DECEASED-NAME<br>(Type or print)  |                              | First  | Middle  | Last  | 2a. DATE OF DEATH |   | 2b. HOUR |  |
| Howard   |                              | Leonard  | Miller. | Month 4 Day 15 Year 68  |                   | 6:30 AM   |          |  |
| 3. SEX   | 4. RACE                      | 5. DATE OF BIRTH   |         | 6. AGE (In years last birthday)   |                   | IF UNDER 1 YEAR   |          | IF UNDER 24 HRS.                             |
| M  | W                            | 3-28-1901  |         | 67 YRS.   |                   | MONTHS DAYS   |          | HOURS MIN.                                   |
| 7a. BIRTHPLACE (State or foreign country)  | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |         | 9. COUNTY OF DEATH  |                   |   |          |  |
| Md.  | USA                          |  |         | Baltimore   |                   | Md.   |          |  |
| 10. CITY OR TOWN OF DEATH  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |         | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                   | 12b. KIND OF BUSINESS OR INDUSTRY   |          |  |
| Baltimore  |                              | Chesapeake Hosp.   |         | Truck Driver  |                   | Trucking  |          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |                              | 13b. COUNTY  |         | 13c. CITY OR TOWN   |                   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |          | 13e. STREET AND NUMBER                       |
| ma   |                              | Balto.   |         | Monkton   |                   |   |          | York Rd.                                     |
| 14. FATHER'S NAME  |                              | 15. MOTHER'S MAIDEN NAME   |         |   |                   |   |          |  |
| First Middle Last  |                              | First Middle Last  |         |   |                   |   |          |  |
| 3 Howard Miller  |                              | Tempe Mayes  |         |   |                   |   |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |                              | 16b. SOCIAL SECURITY NO.   |         | 17. INFORMANT   |                   | Address   |          |  |
| No   |                              | 215-10-7471A   |         | Daisy B. Miller   |                   | York Rd. Monkton, Md.   |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |                              |  |         |   |                   |   |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |                              |  |         |   |                   |   |          |  |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>   |                              |  |         |   |                   |   |          | Years -                                      |
| DUE TO, OR AS A CONSEQUENCE OF   |                              |  |         |   |                   |   |          |  |
| (b) <u>Pneumonia</u>   |                              |  |         |   |                   |   |          | Hours -                                      |
| DUE TO, OR AS A CONSEQUENCE OF   |                              |  |         |   |                   |   |          |  |
| (c)  |                              |  |         |   |                   |   |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |                              |  |         |   |                   |   |          |  |
| <u>4221</u> <u>Cerebral Vascular Accident</u>  |                              |  |         |   |                   |   |          |  |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |         | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |                   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |          |  |
|  |                              |  |         |   |                   |   |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |         | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |                   |   |          |  |
|  |                              |  |         |   |                   |   |          |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |         | 21f. LOCATION Street or R.F.D. No.  |                   | City or Town  |          | County State                                 |
|  |                              |  |         |   |                   |   |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/28</u> , 19 <u>68</u> , to <u>4/14</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                              |  |         |   |                   |   |          |  |
| 22b. SIGNATURE   |                              | DEGREE   |         | ATTENDING PHYS.   |                   | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>       |          | 22c. DATE SIGNED                             |
| <u>Luis J. Elias, M.D.</u>   |                              |  |         | <input checked="" type="checkbox"/>   |                   |   |          | <u>4/15/68</u>                               |
| 22d. PHYSICIAN'S NAME (Type)   |                              | 22e. ADDRESS   |         |   |                   |   |          |  |
| LUIS J. ELIAS, M.D.  |                              | 1701 Meridene Drive, Balto., Md. 21212   |         |   |                   |   |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                              | 23b. DATE  |         | 23c. NAME OF CEMETERY OR CREMATORY  |                   | 23d. LOCATION (City or Town) (County) (State)                                     |          |  |
| Burial   |                              | 4/18/68  |         | Hereford Baptist Cem.   |                   | Parkton, Balto. Md.   |          |  |
| 24. FUNERAL DIRECTOR   |                              | ADDRESS  |         | 25a. REC'D BY REGISTRAR   |                   | 25b. REGISTRAR'S SIGNATURE  |          |  |
| <u>L. Jacob Hartenstein</u>  |                              | <u>New Freedom, Pa.</u>  |         | DATE APR 22 1968  |                   | <u>Charles Judge</u>  |          |  |

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| MIDDLE  |  |  |  |  |  |  |  |  |  | LAST   |  |  |  |  |  |  |  |  |  | 20. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | 2. DATE OF DEATH   |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Henry James Mitchell  |  |  |  |  |  |  |  |  |  | Month 4 Day 25 Year 68   |  |  |  |  |  |  |  |  |  | M  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR        |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. |  |  |  |  |  |  |  |  |  |
| Male  |  |  |  |  |  |  |  |  |  | Cau  |  |  |  |  |  |  |  |  |  | 4/8/86   |  |  |  |  |  |  |  |  |  | 82 YRS.  |  |  |  |  |  |  |  |  |  | MONTHS DAYS HOURS MIN. |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |  |  |  |  |  | Md.                    |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| England   |  |  |  |  |  |  |  |  |  | USA  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Catonsville   |  |  |  |  |  |  |  |  |  | 1215 Kiethmont Rd  |  |  |  |  |  |  |  |  |  | Auditor  |  |  |  |  |  |  |  |  |  | Retired  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Md.   |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |  |  |  |  |  | Catonsville  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |  |  |  |  |  |  |  |  | 1215 Kiethmont Rd      |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| First Middle Last   |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| William Mitchell  |  |  |  |  |  |  |  |  |  | Nellie Bulpitt   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | 1215 Kiethmont Rd  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| No  |  |  |  |  |  |  |  |  |  | 215-01-7324  |  |  |  |  |  |  |  |  |  | Mrs. Lena L. Mitchell  |  |  |  |  |  |  |  |  |  | Balt. Md. 21228  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a)   |  |  |  |  |  |  |  |  |  | Massive Cerebral Hemorrhage  |  |  |  |  |  |  |  |  |  | 5 minutes  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 4319  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  | Cerebral Arteriosclerosis  |  |  |  |  |  |  |  |  |  | 10 years   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |  |  |  |  |  |  | (b)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  | (c)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 331X  |  |  |  |  |  |  |  |  |  | Previous Cerebral Vaso. accident in 1964                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 1964, to April 1968, that (I) (we) last saw the deceased alive on April 19 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  |  |  | DEGREE   |  |  |  |  |  |  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Max J. Miller   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 4/26/68  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | 1047 Ingleside Ave Balt. Md. 21228   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Burial  |  |  |  |  |  |  |  |  |  | 4/29/68  |  |  |  |  |  |  |  |  |  | Meadowridge  |  |  |  |  |  |  |  |  |  | AA County, Maryland  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |
| Wm. Cook-Brooks West Inc. Balt. Md. 21228   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | DATE APR 30 1968   |  |  |  |  |  |  |  |  |  | Charles Judge  |  |  |  |  |  |  |  |  |  |                        |  |  |  |  |  |  |  |  |  |                  |  |  |  |  |  |  |  |  |  |

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## Abstract

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## References

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |                             |  |  |   |   |  |  |  |
|--|--|--|--|---|-----------------------------|--|--|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |                             |  |  |   |   |  |  |  |
| 05315<br>Item 8 Film G399 4/26/68 kk CERTIFICATE OF DEATH  |  |  |  |   |                             |  |  |   |   |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>JOHN PENSE MOLLETT   |  |  |  |   |                             | 2a. DATE OF DEATH Month Day Year<br>4 18 68  |  |   | 2b. HOUR<br>3:25 PM                             |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>12-19-1920  |                             |  | 6. AGE (in years last birthday)<br>47 YRS.   |   | IF UNDER 1 YEAR MONTHS DAYS                     |  | IF UNDER 24 HRS. HOURS MIN                   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>India   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                       |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. COUNTY OF DEATH<br>Baltimore Md.  |  |   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Greater Balto. Med. Center |   |                             | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY               |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Towson |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>205 Duke of York Lane |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>John Donald Mellott   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Elizabeth Pence   |                             |  |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>212 34 3665   |                             | 17. INFORMANT Address<br>Hospital Records  |  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Malignant melanoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |                             |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>1909  |  |  |  |   |                             |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |                             | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>YES |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                             |  |  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   |                             | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/18, 1968</u> to <u>4/18, 1968</u> , that (I) (we) lost saw the deceased alive on <u>4/18, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |  |  |  |   |                             |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><u>John E. Adams</u>   |  |  |  |   |                             | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br>4/18/68                     |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>John E. Adams, M. D.   |  |  |  |   |                             | 22e. ADDRESS<br>Greater Baltimore Medical Center   |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial  |  | 23b. DATE<br>4-22-68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley  |                             |  | 23d. LOCATION (City or Town) (County) (State)<br>Cockeysville, Baltimore, Md.        |   |   |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br>Wm. Cook-Brooks Towson, Towson, Md. 21204  |  |  |  |   |                             | 25a. REC'D BY REGISTRAR<br>DATE APR 23 1968  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                          |   |  |  |  |

11330

MADE IN U.S.A.

11330

(1)

MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <span>05316</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH<br/>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>05318</span> </div>   |  |  |  |   |                                    |  |  |   |   |  |  |
|--|--|--|--|---|------------------------------------|--|--|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Harry E. Mooneyhan</b>  |  |  |  | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>8</b> Year <b>1968</b>   |                                    |  |  | 2b. HOUR<br><b>7A</b> M   |   |  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>Cau.</b>   |  | 5. DATE OF BIRTH<br><b>4-19-1900</b>  |                                    |  |  | 6. AGE (In years last birthday)<br><b>67</b> YRS.                         |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>S. Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                    | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Fullerton</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>4134 Grape Hill</b> |   |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Self-employed</b>                        |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Barbar</b>      |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |  |  | 13b. COUNTY <b>Baltimore</b>   |   | 13c. CITY OR TOWN <b>Fullerton</b> |  | 13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>4134 Grape Hill Avenue</b> |  |  |
| 14. FATHER'S NAME First <b>Henry</b> Middle <b>E.</b> Last <b>Mooneyhan</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>Lula</b> Middle <b>Scarborough</b> Last <b>Scarborough</b>  |                                    |  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-12-7236</b>   |   |                                    | 17. INFORMANT Address<br><b>James N. Mooneyhan 5502 Catalhe Road 21214</b>   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>coronary occlusion</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>coronary artery disease 24 yrs</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>arteriosclerotic CVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |                                    |  |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>  |  |  |  |   |                                    |  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |                                    | 20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?      |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                    |  |  |   |   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>May 13, 1968</b> to <b>April 4, 1968</b> , that (I) (we) last saw the deceased alive on <b>4-2-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above: (I) (we) (did) (did not) view the body after death.  |  |  |  |   |                                    |  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Richard R. Rigler</b>   |  |  |  |   |                                    | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/9/68</b>   |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>RICHARD R. RIGLER, M.D.</b>   |  |  |  |   |                                    | 22e. ADDRESS<br><b>1 W. Overlea Ave., Balto 6, Md.</b>   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4-11-1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cemetery</b>  |                                    |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Co. Md.</b> |   |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Laurel Funeral Home 7401 Belair Road</b>  |  |  |  |   |                                    | 25a. REC'D BY REGISTRAR<br><b>APR 15 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James N. Mooneyhan</b>                   |   |  |  |

0135

REMARKS OF DEATH

01310

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| <div style="display: flex; justify-content: space-between;"> <span>05317</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH<br/>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>05319</span> </div>   |  |  |  |  |  |   |  |  |   |  |  |  |  |   |                           |       |  |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|---|---------------------------|-------|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br><b>OLIVER</b>   |  |  | Middle<br><b>- -</b>  |  |  | Last<br><b>MOORE</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>28</b> Year <b>1968</b> |  |   | 2b. HOUR<br><b>2:00AM</b> |       |  |
| 3. SEX<br><b>MALE</b>  |  |  | 4. RACE<br><b>NEGRO</b>  |  |  | 5. DATE OF BIRTH<br><b>8/24/89</b>  |  |  | 6. AGE (In years<br>last birthday)<br><b>78</b> YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                       |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b> |                           |       |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>VIRGINIA</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |  |  |  |   |                           |       |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>VETERANS ADMIN. HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>LABORER</b>  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>AMER. RADIATOR</b>                                   |  |  |  |  |   |                           |       |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>811 McALEER COURT</b>                     |  |   |                           |       |  |
| 14. FATHER'S NAME<br>First <b>CLAYBURN</b> Middle <b>- -</b> Last <b>MOORE</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>ELLA</b> Middle <b>- -</b> Last <b>SCOTT</b>                                  |  |  |   |  |  |   |  |  |  |  |   |                           |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>YES</b> (If yes give war or dates of service) <b>WWI</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213 01 42 05</b>  |  |  | 17. INFORMANT<br>Address<br><b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>   |  |  |   |  |  |  |  |   |                           |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>DIABETES MELLITUS</b>  |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 WEEKS</b>      |  | YEARS   |                           | YEARS |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>GANGRENE LEFT 5th TOE, ARTERIOSCLEROSIS OBLITERANS LOWER EXTREMITIES</b>  |  |  |  |  |  |   |  |  |   |  |  |  |  |   |                           |       |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |  |   |                           |       |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |  |   |                           |       |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                    |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |  |  |   |                           |       |  |
| 22a. I certify that <del>(x)</del> (this hospital) attended the deceased from <b>MAR 19</b> , 19 <b>68</b> , to <b>APR 28</b> , 19 <b>68</b> , that <del>(x)</del> (we) last<br>saw the deceased alive on <b>APR 28</b> , 19 <b>68</b> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the<br>causes stated above, <del>(x)</del> (we) (did) <del>to</del> view the body after death. |  |  |  |  |  |   |  |  |   |  |  |  |  |   |                           |       |  |
| 22b. SIGNATURE<br><i>Elsa M. Goris</i> DEGREE ATTENDING <input type="checkbox"/> MED. <input type="checkbox"/> STAFF <input checked="" type="checkbox"/><br>PHYS. DIRECTOR PHYS. STAFF   |  |  |  |  |  |   |  |  |   |  |  | 22c. DATE SIGNED<br><b>4/28/68</b>                                     |  |   |                           |       |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>ELSA M. GORIS, M.D.</b>  |  |  | 22e. ADDRESS<br><b>VAH, FT. HOWARD, MD.</b>  |  |  |   |  |  |   |  |  |  |  |   |                           |       |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>Apr 28, 1968</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moore's Cem.</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Petersburg VA.</b>                          |  |  |  |  |   |                           |       |  |
| 24. FUNERAL DIRECTOR<br><i>Elroy O. Wilson</i><br><b>ELROY WILSON</b>  |  |  | ADDRESS<br><b>2001 ORLEANS ST.,<br/>BALTIMORE, MD.</b>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 29 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |  |  |  |   |                           |       |  |

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| 05318  |  |  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                  |  |  |  |                        |  |  |  |                  |  |  |  | 05320                      |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|------------------|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|--|--|
| Item 17 Film G399 4/22/68 kk   |  |  |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |                        |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  |  | First Middle Last  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |                        |  | 2b. HOUR   |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| William Kelso Morrill  |  |  |  |  |  | Sr   |  |  |  |  |  | April 11, 1968   |  |  |  |                        |  | M  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  |  |  | 4. RACE  |  |  |  | 5. DATE OF BIRTH   |  |  |  | 6. AGE (In years last birthday)  |  |  |  | IF UNDER 1 YEAR        |  |  |  | IF UNDER 24 HRS. |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| Male   |  |  |  | Caucasian  |  |  |  | Dec. 15, 1903  |  |  |  | 64 YRS.  |  |  |  | MONTHS DAYS            |  |  |  | HOURS MIN        |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH   |  |  |  |                        |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| Maryland   |  |  |  | U.S.A.   |  |  |  |  |  |  |  | Baltimore  |  |  |  | Md.                    |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |                        |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| Towson   |  |  |  | Pronounced @ St. Jos. Hosp.  |  |  |  | Prof. of Math.   |  |  |  | University   |  |  |  |                        |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  | 13b. COUNTY  |  |  |  | 13c. CITY OR TOWN  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  | 13e. STREET AND NUMBER |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| Maryland   |  |  |  | Baltimore  |  |  |  | Towson   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |  |  | 534 Stevenson La.      |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |                        |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| First Middle Last  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  |                        |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| Bert Morrill   |  |  |  |  |  | Edna Fort  |  |  |  |  |  |  |  |  |  |                        |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  | 17. INFORMANT  |  |  |  |                        |  | Address  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| X No   |  |  |  |  |  | 220-30-2822  |  |  |  |  |  | Mary Mrs. Edna C. Morrill wf.  |  |  |  |                        |  | 534 Stevenson La.  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Acute Myocardial Infarction  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  | 3.5 minutes  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| (b) Coronary Arteriosclerosis  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  | 2 years  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| (c)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 4201 Granulomatous Arteritis   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 490 |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)              |  |  |  |                        |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                 |  |  |  |                        |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 1963, to April 1968, that (I) (we) last saw the deceased alive on March 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  |  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  | 22c. DATE SIGNED   |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| W. Gordon Walker M.D. DEGREE   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  | 12 April 1968  |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) W. GORDON WALKER  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                        |  | 22e. ADDRESS Johns Hopkins Hospital                                      |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |                        |  | 23d. LOCATION (City or Town) (County) (State)                            |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| Burial   |  |  |  |  |  | April 15, 1968   |  |  |  |  |  | New London Cemetery  |  |  |  |                        |  | New London, Pennsylvania   |  |                  |  |  |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |                        |  |  |  |                  |  |  |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |  |  |  |  |  |  |  |  |
| Wm. Cook-Brooks, Towson Inc. 1050 N. York Rd.  |  |  |  |  |  |  |  |  |  |  |  | DATE APR 15 1968   |  |  |  |                        |  |  |  |                  |  |  |  | Charles Judge              |  |  |  |  |  |  |  |  |  |  |  |

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DEPARTMENT OF THE ARMY

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OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D. C.  
JAN 10 1918

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-1. Page 5 may be retained for your files.

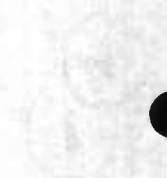
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                  |  |                                 |  |   |  |                             |  |  |  |  |
|---|--|------------------|--|---------------------------------|--|---|--|-----------------------------|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |                                 |  |   |  |                             |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or Print) <b>ELIZABETH MARY MORRIS</b>  |  |                  | First Middle Last  |                                 |  | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year <b>APR 10 1968</b>   |  |                             | 2b. HOUR <b>10A</b> M  |  |  |  |
| 3. SEX <b>F</b>   |  | 4. RACE <b>W</b> |  | 5. DATE OF BIRTH <b>6-30-83</b> |  | 6. AGE (In years last birthday) <b>84</b> YRS   |  | IF UNDER 1 YEAR MONTHS DAYS |  | IF UNDER 24 HRS. HOURS MIN.                  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |  |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |                                 |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>        |  |                             | 9. COUNTY OF DEATH <b>Baltimore</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Cockeysville</b>   |  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>220 Padonia Road</b> |                                 |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>  |  |                             | 12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  |                  | 13b. COUNTY <b>Baltimore</b>   |                                 |  | 13c. CITY OR TOWN <b>Cockeysville</b>   |  |                             | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>220 Padonia Road</b> |  |
| 14. FATHER'S NAME First Middle Last <b>Frank Measley</b>  |  |                  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>Elizabeth ?</b>  |                                 |  |   |  |                             |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  |                  | 16b. SOCIAL SECURITY NO. <b>None</b>   |                                 |  | 17. INFORMANT ADDRESS <b>Mrs. Paul Morris, Padonia Rd., Cockeysville, Md.</b>   |  |                             |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRO-VASCULAR ACCIDENT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4129</b><br>(b) <b>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4221</b>                     |  |                  |  |                                 |  |   |  |                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |                  |  |                                 |  |   |  |                             |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                 |  |   |  |                             | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>  |                                 |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |                             |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                         |                                 |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |                             |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |  |                                 |  |   |  |                             |  |  |  |  |
| ACTUAL SIGNATURE <b>William A. Pilsbury</b>   |  |                  | EXAMINER'S NAME (Type) <b>William A. Pilsbury</b>  |                                 |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |                             | 22b. DATE SIGNED <b>4/10/68</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  |                  | 23b. DATE <b>April 13, 1968</b>  |                                 |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial</b>   |  |                             | 23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Maryland</b>                  |  |  |  |
| 24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>  |  |                  |  |                                 |  | 25a. REC'D BY REGISTRAR <b>APR 15 1968</b>  |  |                             | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |  |  |

05821

05821

TOP SECRET  
REPRODUCTION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05320

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05322

|   |                              |  |   |   |                                  |  |   |  |
|---|------------------------------|--|---|---|----------------------------------|--|---|--|
| 1. DECEASED-NAME (Type or print)  |                              | First  | Middle  | Last  | 2a. DATE OF DEATH                |  | 2b. HOUR                                  |  |
| RITA  |                              | M.   | MORRISON  |   | Month Day Year<br>April 26, 1968 |  | 2:05am                                    |  |
| 3. SEX  | 4. RACE                      |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| Female  | White                        |  | April 12, 1903  |   | 65 YRS.                          |  |   |  |
| 7a. BIRTHPLACE (State or foreign country)   | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH               |  | Md.                                       |  |
| Maryland  | U.S.A.                       |  |   |   | Baltimore                        |  |   |  |
| 10. CITY OR TOWN OF DEATH   |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| Towson  |                              | St. Joseph Hospital  |   | Housewife   |                                  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN   |                                  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER                       |
| Maryland  |                              |  |   | Baltimore   |                                  |  |   | 1609 Woodbourne Ave. 21212                   |
| 14. FATHER'S NAME   |                              | First  | Middle  | Last  | 15. MOTHER'S MAIDEN NAME         |  | First                                     | Middle Last                                  |
| Wm. E. Connolly   |                              |  |   |   | Mary Catherine Whelple           |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |                              | (If yes give war or dates of service)  |   | 16b. SOCIAL SECURITY NO.  |                                  | 17. INFORMANT Address  |   |  |
| no  |                              |  |   |   |                                  | Mrs. Doris Anderson-Sister   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Edema</u><br><u>2381</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Brain Tumor</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(d) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><u>237X</u> |                              |  |   |   |                                  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |                                  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |  |
| 4-24-68   |                              | Brain Tumor  |   |   |                                  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |                                  |  |   |  |
|   |                              |  |   |   |                                  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |                                  |  |   |  |
|   |                              |  |   |   |                                  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 21</u> , 19 <u>68</u> , to <u>April 26</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>April 26</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |                              |  |   |   |                                  |  |   |  |
| 22b. SIGNATURE <u>Jaime Ambrad M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |                              |  |   |   |                                  | 22c. DATE SIGNED April 26, 1968  |   |  |
| 22d. PHYSICIAN'S NAME (Type) JAIME AMBRAD, M.D.   |                              |  |   | 22e. ADDRESS 7620 YORK RD. Towson, Maryland 21204                                       |                                  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |                                  | 23d. LOCATION (City or Town) (County) (State)  |   |  |
| Burial  |                              | 4/29/68  |   | Cathedral   |                                  | Balto.   |   |  |
| 24. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home-6500 York Rd-12  |                              |  |   | 25a. REC'D BY REGISTRAR DATE APR 30 1968  |                                  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A 15  
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05321

05323

|   |   |   |   |  |
|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>EDWARD L. MOULDS Sr.</b>   |   |   | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>5</b> Year <b>68</b> 11:15A M                        |  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br><b>9/10/94</b>  |   | 6. AGE (In years last birthday)<br><b>73</b> YRS.                          |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY,</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET. ADM. HOSPITAL</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>BUS DRIVER</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TRANSIT CO.</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br><b>1905 E. Ramblewood Road</b>                   |
| 14. FATHER'S NAME First Middle Last<br><b>James Moulds</b>  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Margaret Martin</b>  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>WW I</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>213 10 15 98</b>   |   | 17. INFORMANT Address<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>INFARCTION OF MYOCARDIUM WITH HEART BLOCK</b><br><b>4109</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>ARTERIOSCLEROTIC CORONARY THROMBOSIS</b><br><b>4201</b> DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>DIABETES MELLITUS</b>  |   |   |   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |
| 22a. I certify that <del>(x)</del> (this hospital), attended the deceased from <b>2/21/68</b> , 19__, to <b>4/5/68</b> , 19__, that <del>(x)</del> (we) last saw the deceased alive on <b>4/5/68</b> , 19__, and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(x)</del> (we) (did) ( <del>do not</del> ) view the body after death.                           |   |   |   |  |
| 22b. SIGNATURE<br><b>John D. Talbert, MD</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |   |   |   | 22c. DATE SIGNED<br><b>4/5/68</b>  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M. D.</b>   |   | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |   |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br><b>BURIAL</b>   | 23b. DATE<br><b>4-8-1968</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN CEMETERY</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                     |  |
| 24. FUNERAL DIRECTOR<br><b>LILLY &amp; ZEILER FUNERAL</b><br>ADDRESS<br><b>EASTERN AVE. &amp; WOLFE STS. BALTIMORE, MD.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>APR 9 1968</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

MEDICAL CERTIFICATION

1933

1933

STATE OF MARYLAND  
DEPARTMENT OF THE TREASURY  
BUREAU OF TAXATION

FOR THE YEAR ENDING DECEMBER 31, 1933  
IN ACCORDANCE WITH THE PROVISIONS OF THE  
MARTIN LUTHER KING, JR. ACT

AND THE PROVISIONS OF THE  
MARTIN LUTHER KING, JR. ACT  
AS AMENDED BY THE

LEGISLATURE OF THE STATE OF MARYLAND  
IN THE YEAR 1933

AND THE PROVISIONS OF THE  
MARTIN LUTHER KING, JR. ACT  
AS AMENDED BY THE

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IN THE YEAR 1933

AND THE PROVISIONS OF THE  
MARTIN LUTHER KING, JR. ACT  
AS AMENDED BY THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle   |  | Last   |  | 20. DATE OF DEATH  |  | 2b. HOUR                                     |  |
| JAMES   |  | J.   |  | MULHERAN   |  | SR.  |  | APRIL 22 1968  |  | 10:27  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.                             |  |
| MALE  |  | WHITE  |  | JULY 28, 1894  |  | 73   |  | MONTHS   |  | DAYS   |  |
| 70. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |  | 9. COUNTY OF DEATH   |  |  |  |  |  |
| WEST VIRGINIA   |  | U.S.A.   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                     |  | BALTIMORE  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |
| TOWSON  |  | ST. JOSEPH HOSPITAL  |  | SHIPPING DEPT  |  | BETH. STEEL  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |  |  |
| MARYLAND  |  | BALTIMORE  |  | DUNDALK  |  | NO   |  | 3424 SOLLERS POINT RD. #22   |  |  |  |
| 14. FATHER'S NAME   |  | First  |  | Middle   |  | Last   |  | 15. MOTHER'S MAIDEN NAME   |  | First Middle Last                            |  |
| GEORGE  |  | MULHERAN   |  |  |  |  |  | NORA MCDONALD  |  | #  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (or unknown) <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address  |  |  |  |  |  |
| Yes   |  | WWE 213-09-0517  |  | JANE MCG. MULHERAN   |  | # 15   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Heart failure   |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |
| (b) Pulmonary fibrosis  |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |
| (c) Emphysema   |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |  |  |
| 5271  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)        |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |  | Street or R.F.D. No.   |  | City or Town   |  | County State                                 |  |
| While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from APRIL 22, 1968, to April 22, 1968, that (I) (we) last saw the deceased alive on APRIL 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |
| Jose Nepomuceno, M.D.   |  |  |  |  |  |  |  | April 23, 1968   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |
| Jose Nepomuceno, M.D.   |  |  |  |  |  |  |  | 7620 York Rd., Towson, Md. 21204                                     |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |  |
| BURIAL  |  | 4/25/1968  |  | BALTIMORE, NATIONAL  |  | BALTIMORE, MD  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                   |  |
| Ed. Brooks Roadway Headache, Md   |  |  |  |  |  |  |  | APR 25 1968  |  | J. J. J. J.                                  |  |

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| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br>CERTIFICATE OF DEATH  |  |  |   |   |   |   |   |  |  |  |
|---|--|--|---|---|---|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Clarence B. Mumford</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>20</b> Year <b>1968</b>  |   |   | 2b. HOUR<br><b>9:15</b> P. M.   |   |  |  |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>  |   | 5. DATE OF BIRTH<br><b>April 17, 1884</b>   |   | 6. AGE (In years last birthday)<br><b>84</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.        |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>                                 |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SPRING GROVE STATE HOSP.</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>fisherman</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FISH</b> |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Cecil</b>   |   | 13c. CITY OR TOWN<br><b>Chesapeake</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>none</b>        |  |
| 14. FATHER'S NAME First Middle Last<br><b>Benjamin MUMFORD</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary E. NO INFO</b>  |   |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>No</b> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-30-4505</b>  |   | 17. INFORMANT Address<br><b>Records: SPRING GROVE STATE HOSPITAL</b>  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Anest.</b><br><b>4129</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>AS CVD.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)                                   |  |  |   |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4330</b>   |  |  |   |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |
| 22a. I certify that <b>as</b> (this hospital) attended the deceased from <b>May 6</b> , 19 <b>64</b> , to <b>April 20</b> , 19 <b>68</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>4/20</b> , 19 <b>68</b> , and that in (my) <b>(we)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> (did) (did not) view the body after death. |  |  |   |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Robert Fisher M.D.</b> DEGREE  |  |  |   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4/20/68</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Robert Fisher M.D.</b>   |  |  |   |   | 22e. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4-25-68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETHEL</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>CHESAPEAKE CITY CEIL MD</b>                             |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>PIPPIN FUNERAL HOME ELKTON, MD</b>   |  |  |   |   | 25a. REC'D BY REGISTRAR<br><b>DATE APR 24 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

MEDICAL CERTIFICATION

03325

CENTRAL OF PENN.

03325





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

05324

05326

|  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Michele</b>   |  |  | First <b>Lee</b>  |  |  | Middle <b>NEHRKORN</b>  |  |  | Last   |  |  | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>22</b> Year <b>68</b> |  |  | 2b. HOUR <b>5:35</b> P <b>M</b>   |  |  |
| 3. SEX<br><b>Female</b>  |  |  | 4. RACE<br><b>White</b>   |  |  | 5. DATE OF BIRTH<br><b>3/30/60</b>  |  |  | 6. AGE (in years last birthday)<br><b>8</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                 |  |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b>                               |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  | Md.  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Owings Mills</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Rosewood State Hosp.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Dependent</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>   |  |  |  |  |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>6745 Roberts Avenue</b>             |  |  |   |  |  |
| 14. FATHER'S NAME<br>First <b>Robert</b> Middle <b>Leroy</b> Last <b>Nehrkorn</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Barbara</b> Middle <b>Bernice</b> Last <b>Bright</b>                   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>no</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>none</b>   |  |  | 17. INFORMANT<br><b>Rosewood Records, Owings Mills, Maryland</b>  |  |  | Address  |  |  |  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Atelectasis Bilateral Marked</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Cerebral insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>355X</b><br>4379<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |  |   |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 wks</b><br><b>7 yrs.</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Excepta loathing due to postnatal Cerebral infection</b>   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b>           |  |  |  |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                |  |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |   |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>6/2</b> , 19 <b>66</b> , to <b>4/22</b> , 19 <b>68</b> , that (1) (we) last saw the deceased alive on <b>4/22</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (do not) view the body after death.   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Richard A. Jones</b>  |  |  | DEGREE  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><b>4/23/68</b>   |  |  |  |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Richard A. Jones, M.D.</b>  |  |  | 22e. ADDRESS<br><b>Rosewood State Hosp., Owings Mills, Md.</b>  |  |  |   |  |  |  |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>4/25/68</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Carmel Cemetery</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                  |  |  |  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>   |  |  | ADDRESS   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 25 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |  |  |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11334

OFFICE OF THE

11334

MEMORANDUM FOR THE RECORD  
SUBJECT: [Illegible]  
DATE: [Illegible]  
TO: [Illegible]  
FROM: [Illegible]  
[Illegible text follows]

[Illegible text follows]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

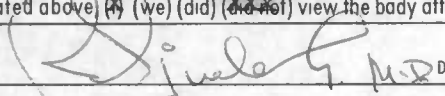

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |  |   |   |
|---|--|--|--|---|---|--|--|---|---|
| 1. DECEASED-NAME (Type or print)<br><b>LEO ROBERT NESS</b>  |  |  | First Middle Last  |   |   | 20. DATE OF DEATH<br>Month <b>April</b> Day <b>24</b> Year <b>1968</b>                                     |  |   | 2b. HOUR<br><b>11:45 AM</b>                                     |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>May 22 1917</b>  |   |  | 6. AGE (In years last birthday)<br><b>50</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Fort Howard</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Veterans Administration</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Mechanic</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Public Trasp.</b> |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Reisterstown</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>241 Main Street</b>                |
| 14. FATHER'S NAME First Middle Last<br><b>Jacob B. Ness</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Agnes Walsh</b>   |   |   |  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>Yes</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>WW-11 214 12 07 99</b>  |   | 17. INFORMANT Address<br><b>Clinical Rcds, VA Hospital, Fort Howard, Md.</b>      |  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLI</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF                    |  |  |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Weeks<br>Years  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4200</b>   |  |  |  |   |   |  |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |   | City or Town   |  | County State  |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 18, 1968</b> , to <b>April 24, 1968</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>April 24, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |  |   |   |
| 22b. SIGNATURE<br><b>J. D. Talbert, M.D.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |  |  |   |   |  |  | 22c. DATE SIGNED<br><b>4/24/68</b>                        |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>J. D. TALBERT, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>VA Hospital, Fort Howard, Maryland</b>   |   |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>April 27, 68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen Memorial</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Reisterstown, Maryland</b>                             |  |   |   |
| 24. FUNERAL DIRECTOR<br><b>Eline Funeral Home</b><br><b>Reisterstown, Maryland</b>  |  |  |  | 25a. RECD BY REGISTRAR<br><b>APR 26 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jones</b>   |  |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 05326  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  | 05328   |  |  |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| Items 5 & 6 Film G399 4/22/68 kk   |  |  |  | CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First  |  | Middle  |  | Last   |  | 2a. DATE OF DEATH   |  | 2b. HOUR                                     |  |
| Thelma   |  | Lillian  |  | Neukam  |  |  |  | Month April Day 6 Year 1968   |  | 10:10  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.                             |  |
| Female   |  | White  |  | March 14, 1907  |  | 61 YRS.  |  | MONTHS DAYS   |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |   |  | Md.  |  |
| Maryland   |  | U.S.A.   |  |   |  | Baltimore  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |
| Towson   |  | St. Joseph Hospital  |  | homemaker   |  |  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER  |  |  |  |
| Maryland   |  |  |  | Baltimore   |  |  |  | 2821 Mayfield Ave. 21213  |  |  |  |
| 14. FATHER'S NAME  |  | First  |  | Middle  |  | Last   |  | 15. MOTHER'S MAIDEN NAME  |  | First Middle Last                            |  |
| Harry V. Baker   |  |  |  |   |  |  |  | Lillian Harris  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | Address  |  |   |  |  |  |
|  |  |  |  | George Neukam, husband, above   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adynamic ileus</b><br><b>596.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pelvic abscess</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Perforated urinary bladder</b> |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>606X</b>  |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |  |  |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from <u>April 1, 1968</u> , to <u>April 6, 1968</u> , that <del>he</del> (we) last saw the deceased alive on <u>April 6, 1968</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above <del>by</del> (we) (did) <del>(did not)</del> view the body after death.                  |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><br>DEGREE  |  |  |  |   |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>4/7/68                   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Reynaldo Orjuela-Gomez, M.D.   |  |  |  |   |  |  |  | 22e. ADDRESS<br>7620 York Rd.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |   |  |  |  |
| Burial   |  | 4/10/68  |  | Holy Redeemer Cemetery  |  | Baltimore, Md.   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.<br>3331 Brehms Lane   |  |  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE APR 10 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>             |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |  |   |   |  |   |  |
|--|--|---|--|--|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |  |   |   |  |   |  |
| CERTIFICATE OF DEATH   |  |   |  |  |   |   |  |   |  |
| 1. DECEASED-NAME (Type or print)   |  |   | First Middle Last  |  |   | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |
| Robert   |  |   | I. Nevitt  |  |   | April 15, 1968  |  | 6:30 a.m.   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR   |  |
| male   |  | white   |  | Feb. 9, 1893   |   | 74 75 YRS.  |  | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Maryland   |  | U. S.   |  |  |   | Baltimore   |  | Md.   |  |
| 10. CITY OR TOWN OF DEATH  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Catonsville  |  |   | SPRING GROVE STATE HOSP.   |  |   | clerk   |  | real estate   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |   | 13b. COUNTY  |  |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| Md.  |  |   | Montgomery   |  |   | Takoma Pk.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  |   | 15. MOTHER'S MAIDEN NAME   |  |   | 13e. STREET AND NUMBER  |  | 13f. CITY AND STATE   |  |
| Robert I. Nevitt   |  |   | Annie Schribner  |  |   | 10820 Georgia Ave.  |  | S.S. Md.  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |   | 16b. SOCIAL SECURITY NO.   |  |   | 17. INFORMANT   |  |   |  |
| Yes  |  |   | 17-791-563   |  |   | Records: Marion G. Nevitt, 10820 Georgia Ave. S.S. Md.                                  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 441.2 Ruptured aneurysm of the abdominal aorta  |  |   |  |  |   |   |  |   | Immediate                                    |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, generalized, senile  |  |   |  |  |   |   |  |   | 20 years                                     |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |  |   |   |  |   |  |
| 451X   |  |   |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED        |  |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
|  |  |   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY                                     |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |   |  |
|  |  | HOUR A.M. Month Day Year P.M. 19                        |  |  |   |   |  |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY                                    |  | 21f. LOCATION  |   |   |  |   |  |
| White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | Street or R.F.D. No. City or Town County State   |   |   |  |   |  |
| 22a. I certify that (a) (this hospital) attended the deceased from Feb. 18, 1929, to April 15, 1968, that (a) (we) last saw the deceased alive on April 15, 1968, and that in (a) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. |  |   |  |  |   |   |  |   |  |
| 22b. SIGNATURE   |  |   |  |  |   | 22c. DATE SIGNED  |  |   |  |
| Anthony J. Young, M.D.   |  |   |  |  |   | 4-16-68   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |   |  |  |   | 22e. ADDRESS  |  |   |  |
| Anthony J. Young, M.D.   |  |   |  |  |   | SPRING GROVE STATE HOSPITAL   |  |   |  |
|  |  |   |  |  |   | Baltimore, Maryland 21228   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |  |   |  |
| Burial   |  | Apr. 19, 1968   |  | Rock Creek Cemetery  |   | Washington, D. C.   |  |   |  |
| 24. FUNERAL DIRECTOR   |  |   |  |  |   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |
| C. Glen Carter 8434 Georgia Ave. Warner E. Pumphrey, Inc. Silver Spring, Md.   |  |   |  |  |   | DATE  |  | APR 22 1968   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |   |  |   |  |  |   |  |
|--|--|--|---|---|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |   |  |   |  |  |   |  |
| CERTIFICATE OF DEATH   |  |  |   |   |  |   |  |  |   |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>LLOYD GORDON NEWTON</b>   |  |  |   |   | 2a. DATE OF DEATH Month Day Year<br><b>APRIL 26 1968</b>   |   |  | 2b. HOUR<br><b>3:05 PM</b>                                 |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAU</b>  |   | 5. DATE OF BIRTH<br><b>7-22-1915</b>  |  | 6. AGE (In years last birthday)<br><b>52</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Greater Baltimore Medical Center</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life; even if retired.)<br><b>BUTCHER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                          |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>Box 479 - Rt #16</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>EARL NEWTON</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>SALLY JONES</b>  |   |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>UNK.</b>   |   | 17. INFORMANT Address<br><b>CATHERINE NEWTON ABOVE</b>   |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1460</b><br>IMMEDIATE CAUSE (a) <b>Cerebral metastasis?</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Lymphoepithelioma, Rt. tonsillar fossa</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                  |  |  |   |   |  |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>148X</b>  |  |  |   |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |   |  |
| 22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>3:30 PM 4/26</b> , 19 <b>68</b> , to <b>4/26</b> , 19 <b>68</b> , that <del>the</del> (we) last saw the deceased alive <b>3:30 PM 4/26</b> , 19 <b>68</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>the</del> (we) <del>did</del> (did not) view the body after death. |  |  |   |   |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Jose M. de Leon, MD</b>   |  |  |   |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4/26/68</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JOSE M. DE LEON, MD</b>   |  |  |   |   | 22e. ADDRESS<br><b>GBMC 6701 D. CHARLES ST.</b>  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4/29/68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLLY HILL</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD</b>   |  |  |   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>J.G. CONNELLY SONS 300 MARY</b>   |  |  |   |   | 25a. REC'D BY REGISTRAR<br><b>DATE APR 30 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |  |

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Central meteorological  
hydrographical service



For the use of the  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 15-54  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |  |  |                          |  |  |  |
|---|--|--|--|--|--|--|--|--------------------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |                          |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |                          |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle   |  | Last   |  | 2a. DATE OF DEATH        |  | 2b. HOUR                                     |  |
| Anna  |  | S.   |  | Nollmeyer  |  |  |  | April 15, 1968           |  | M  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR          |  | IF UNDER 24 HRS.                             |  |
| female  |  | white  |  | Jan. 16, 1875  |  | 93 YRS.  |  | MONTHS DAYS              |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                          |  | Md.  |  |
| Germany   |  | U. S.  |  |  |  | Baltimore  |  |                          |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                          |  |  |  |
| Catonsville   |  | SPRING GROVE STATE HOSP.   |  | housewife  |  |  |  |                          |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |  |  |
| Md.   |  | Balto.   |  | Parkville  |  |  |  | 2908 Lingamore Avenue    |  |  |  |
| 14. FATHER'S NAME   |  | First  |  | Middle   |  | Last   |  | 15. MOTHER'S MAIDEN NAME |  | First Middle Last                            |  |
| Peter Krich   |  |  |  |  |  |  |  | Eva.                     |  | ?  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address  |  |                          |  |  |  |
|   |  | 219-05-4870  |  | Records: SPRING GROVE STATE HOSPITAL   |  |  |  |                          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>2509 DUE TO, OR AS A CONSEQUENCE OF <u>AS CVD.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> |  |  |  |  |  |  |  |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>2608</u>  |  |  |  |  |  |  |  |                          |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                          |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |                          |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |                          |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 9-7, 1967, to 4-15, 1968, that (I) (we) last saw the deceased alive on 4-15-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |                          |  |  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |                          |  |  |  |
| Robert Fisher M.D.  |  | 4/15/68  |  | Robert Fisher M.D.   |  | SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228                                     |  |                          |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |                          |  |  |  |
| Burial  |  | 4/18/68.   |  | Holy Redeemer Cemetery   |  | Baltimore, Md.   |  |                          |  |  |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |                          |  |  |  |
| Leonard J. Ruck, Inc. Balto. Md. 21214  |  |  |  | APR 16 1968  |  | Charles Judge  |  |                          |  |  |  |

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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05332

|  |  |   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(Type or print)<br><b>SOPHIE</b>   |  | First<br><b>M.</b>  |  | Middle<br><b>O'BRIEN</b>  |  | Last  |  | 2a. DATE OF DEATH<br><b>April</b> Month <b>7</b> Day <b>1968</b> |  | 2b. HOUR<br><b>11:00A.</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>March 2, 1885</b>  |  | 6. AGE (In years last birthday)<br><b>83</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                   |  | IF UNDER 24 HRS.<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Poland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  | Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>House in the Pines</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>House Work</b>  |  |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Eastwood</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>423 Pembroke Blvd.</b>              |  |   |  |
| 14. FATHER'S NAME First<br><b>?</b>  |  | Middle<br><b>Chimniak</b>   |  | Last  |  | 15. MOTHER'S MAIDEN NAME First<br><b>Unknown</b>  |  | Middle<br><b>Unknown</b>   |  | Last  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown) <b>No</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br><b>Paul W. O'Brien</b>   |  | Address<br><b>423 Pembroke Blvd. Ba. Co., Md.</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b><br>424.9 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Valvular Heart Disease</b><br>302.0 DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypertensive Cardiovascular C.-V. Disease</b><br>203.1<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 wks.</b><br><b>30 yrs.</b><br><b>20 yrs.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>421.4</b>   |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-2-1968</b> , to <b>4-7-1968</b> , that (I) (we) last saw the deceased alive on <b>4-5-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Wilmer K. Gallagher, Sr.</b>  |  | DEGREE  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>4/8/68</b>   |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Wilmer K. Gallagher, Sr.</b>  |  | 22e. ADDRESS<br><b>6209 Frederick Ave. Balto., 21228, Md.</b>   |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b. DATE<br><b>4-10-68.</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>4300 Frederick Ave. Balto., Md.</b>         |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Charles S. Seiler</b>   |  | ADDRESS<br><b>6224 Eastern Ave. Baltimore, 21224, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 10 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

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|---|--|---|--|--|--|
| 05331   |  | MARYLAND STATE DEPARTMENT OF HEALTH   |  | 05333  |  |
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |  |
| Released by Medical Examiner CERTIFICATE OF DEATH   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First Middle Last   |  | 2a. DATE OF DEATH<br>Month Day Year  |  |
| CARRIE  |  | O'CONNOR  |  | April 21 1968  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>September 10, 1888   |  |
| 6. AGE (In years last birthday)<br>79 YRS.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Homemaker |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>St. Joseph Hospital   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  | 13b. COUNTY<br>(Baltimore)  |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Unknown Walden  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Unknown  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>214-03-4066   |  | 17. INFORMANT<br>Address 21206<br>Mr Denzel D. Martin 4603 Powell Avenue                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebrovascular Hemorrhage<br>4319 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 331X (b) DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br>Possible subdural hematoma |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)                      |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 8, 1968, to April 21, 1968, that (I) (we) last saw the deceased alive on April 21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br>Paglinauan, Jr.   |  |   |  | 22c. DATE SIGNED<br>April 21, 1968   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Teodulo Paglinauan, Jr. M.D.  |  |   |  | 22e. ADDRESS<br>7620 York Rd., Towson, Md. 21204   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>4-24-1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Carmel Cemetery  |  |
| 24. FUNERAL DIRECTOR<br>Lassus Funeral Home 7401 Belair Road  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore Co. Md.  |  | 25a. REC'D BY REGISTRAR<br>DATE APR 24 1968  |  |
| 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 10-14  
30M REV. 1-58

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                     |  |  |  |  |   |  |  |   |  |  |
|---|--|---------------------|--|--|--|--|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                     |  |  |  |  |   |  |  |   |  |  |
| CERTIFICATE OF DEATH  |  |                     |  |  |  |  |   |  |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>WILLIAM</b>  |  |                     | First <b>W</b>   |  | Middle <b>IT</b>   |  | Last <b>OGLE</b>  |  | 2a. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>12</b> Year <b>1968</b> |   | 2b. HOUR<br><b>1:55 P.M.</b>                     |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b> |  | 5. DATE OF BIRTH<br><b>JAN. 12, 1888</b> |  |  | 6. AGE (In years last birthday)<br><b>80</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                       |   | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |                     | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.                           |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE, MD.</b>  |  |                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SHANGRI-LA N.Y.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>PAINTER-RET.</b>                                    |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF-EMP.</b>                  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>  |  |                     | 13b. COUNTY <b>BAKD.</b>   |  | 13c. CITY OR TOWN<br><b>CATONSVILLE</b>                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>2207 OLD FREDERICK RD.</b>                |   |  |  |
| 14. FATHER'S NAME<br>First <b>JOSEPH</b> Middle <b>OGLE</b> Last <b>OGLE</b>  |  |                     | 15. MOTHER'S MAIDEN NAME<br>First <b>ANNA</b> Middle <b>WAGNER</b> Last <b>WAGNER</b>                  |  |  |  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  |  |                     | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT<br><b>Mrs. Lulu Schmitt 2207 Old Frederick</b> Address   |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4339</b><br>(b) <b>Arteriosclerosis, generalized</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>3327</b>  |  |                     |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 days</b><br><b>10 years</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Chronic congestive heart failure ② Adenocarcinoma, bladder</b>   |  |                     |  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |                     | 21b. TIME OF INJURY<br>Hour A.M. <b>19</b> Month <b>12</b> Day <b>12</b> Year <b>1968</b><br>P.M.      |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |                     | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                           |  |  | 21f. LOCATION<br>Street or R.F.D. No. <b>100</b> City or Town <b>Baltimore</b> County <b>MD.</b> State <b>MD.</b>                                |   |  |  |   |  |  |
| 22a. I certify that (I) ( <del>has</del> <del>hospital</del> ) attended the deceased from <b>Nov. 17</b> , 19 <b>47</b> , to <b>April 12</b> , 19 <b>68</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>April 6</b> , 19 <b>68</b> , and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death. |  |                     |  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Gilbert E. Rudman, M.D.</b>  |  |                     | 22c. DATE SIGNED<br><b>4/13/68</b>   |  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>GILBERT E. RUDMAN, M.D.</b>   |   |  |  |   |  |  |
| 22e. ADDRESS<br><b>2517 W. BALTO-ST.</b>  |  |                     |  |  |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |  |                     | 23b. DATE<br><b>4-15-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lincoln Park Cem.</b> |  | 23d. LOCATION (City or Town)<br><b>Baltimore</b> (County)<br><b>MD.</b> (State)                 |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Forley-Cornwall JH.</b>  |  |                     | ADDRESS<br><b>Catonville Rd.</b>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 18 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |  |   |  |  |

03300

CERTIFICATE OF ANALYSIS

03300



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>05333</div> <div> <div>1</div> <div> <div>05333</div> <div> <div>05335</div> </div> </div> </div>  |  |  |  |   |  |   |   |  |  |   |   |  |
|---|--|--|--|---|--|---|---|--|--|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>ANN F. OHLENDORF</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>29</b> Year <b>1968</b>                                      |   |  | 2b. HOUR<br><b>4:30 PM</b>                       |   |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>Dec. 13, 1902</b>  |  |   | 6. AGE (In years last birthday)<br><b>65</b> YRS. |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |   | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore Co.</b> Md.  |   |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Chesapeake Manor Conv. Home</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                |   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Stoneleigh</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   | 13e. STREET AND NUMBER<br><b>714 Stoneleigh Rd.</b>                  |  |   |   |  |
| 14. FATHER'S NAME<br>First <b>Albert</b> Middle <b>V.</b> Last <b>Ohlendorf</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Annie</b> Middle <b>Schermeyer</b> Last <b></b>  |  |   |   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>No</b> (If yes give war or dates of service)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>Mr. Albert V. Ohlendorf</b> Address <b>Same</b>   |   |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>174X</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Brain cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>brain metastases</b> |  |  |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Days</b><br><b>Years</b> |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>170X</b>   |  |  |  |   |  |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. <b>19</b> Month <b>April</b> Day <b>27</b> Year <b>1968</b><br>P.M. <b>19</b>     |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  | 21f. LOCATION<br>Street or R.F.D. No. <b>2 W. University Pkwy.</b> City or Town <b>Balto.</b> County <b>Md.</b> State <b>Md.</b>                            |  |   |   |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 20, 1968</b> to <b>April 27, 1968</b> , that (I) (we) last saw the deceased alive on <b>April 27, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>RK Gundry</b>  |  |  |  |   |  |   |   | 22c. DATE SIGNED<br><b>April 30, 1968</b>                            |  |   |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Richard Gundry M. D.</b>   |  |  |  | 22e. ADDRESS<br><b>2 W. University Pkwy. Balto. Md.</b>   |  |   |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>May 2, 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Co., Maryland</b>                            |   |  |  |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce</b>  |  |  |  | ADDRESS<br><b>4001 Ritchie Hwy. (21225)</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAY 6 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |  |   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05334

05336

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pikesville</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>Pikesville, 8, Md.</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Robbs Nursing Home</b>   |                                  | d. STREET ADDRESS<br><b>205 Church Lane</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>Angela</b> Last <b>ONEILL</b>  |                                  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>27</b> Year <b>19 68</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 2, 1882</b> |
| 9. AGE (In years last birthday)<br><b>85</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>1</b> Hours <b>1</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Manicurist</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Carroll Co.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Thomas A. O'Neill</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Rebecca Bloss</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>216-324389</b>  |   |
| 17. INFORMANT<br><b>Mrs. Margaret Kossel</b>  |                                  | Address <b>Pikesville 8, Md.</b><br><b>205 1/2 Church Lane</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>436.9 cerebral vascular accident with H. hemiplegia</b><br>DUE TO (b) <b>5 days</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <b>331X</b><br>DUE TO (c) <b>arteriosclerotic heart disease, temporal arteritis</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>arteriosclerotic heart disease, temporal arteritis</b>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1958</b> , to <b>28 Apr 1968</b> , that (I) (we) lost the deceased alive on <b>26 Apr 1968</b> , and that death occurred at <b>1 A.M.</b> , from causes and on the date stated above.  |                                  |   |   |
| 22a. SIGNATURE<br><b>Paul H Royse</b>   |                                  | 22b. DATE SIGNED<br><b>30 Apr 68</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Paul H Royse</b>   |                                  | 22d. ADDRESS<br><b>1403 Foley La Pikesville Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>May 1, 1968</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville Baltico., Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Frank H. Newell</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>MAY 7 1968</b>  |   |
| ADDRESS<br><b>Pikesville</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |                                 |  |                                   |  |                                |
|---|--|--|--|---|--|---|---------------------------------|--|-----------------------------------|--|--------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |                                 |  |                                   |  |                                |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |                                 |  |                                   |  |                                |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |   |  | 2a. DATE OF DEATH<br>Month Day Year   |                                 |  | 2b. HOUR                          |  |                                |
| Lela Elizabeth Ott  |  |  |  |   |  | THUR April 25, 1968   |                                 |  | 9:10 AM                           |  |                                |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |   | 6. AGE (In years last birthday) |  | IF UNDER 1 YEAR<br>MONTHS DAYS    |  | IF UNDER 24 HRS.<br>HOURS MIN. |
| Female  |  | White  |  | May 26, 1898  |  |   | 69 YRS.                         |  |                                   |  |                                |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH              |  |                                   |  |                                |
| Maryland  |  | U.S.A.   |  |   |  |   | Baltimore                       |  |                                   | Md.  |                                |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                                |
| Towson  |  |  | Greater Balto. Med. Center   |   |  | Housewife   |                                 |  | Home                              |  |                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   |  | 13c. CITY OR TOWN   |                                 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |                                |
| Maryland  |  |  |  |   |  | Baltimore   |                                 | X  |                                   | 2802 Roselawn Ave 21214                      |                                |
| 14. FATHER'S NAME First Middle Last   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last  |  |   |                                 |  |                                   |  |                                |
| Joseph L. Lancaster   |  |  |  | Catherine G. Fink   |  |   |                                 |  |                                   |  |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |                                 |  | Address                           |  |                                |
| No  |  |  |  | 212-32-3452   |  | Edward A. Ott   |                                 |  | Same                              |  |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u><br>2509 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Diabetes Mellitus</u><br>260x<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   |                                 |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Diabetes Mellitus</u>   |  |  |  |   |  |   |                                 |  |                                   |  |                                |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |  |                                |
|   |  |  |  |   |  |   |                                 |  |                                   |  |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |                                 |  |                                   |  |                                |
|   |  |  |  |   |  |   |                                 |  |                                   |  |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |                                 | County   |                                   | State  |                                |
|   |  |  |  |   |  |   |                                 |  |                                   |  |                                |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Sept 1, 1967</u> to <u>April 25, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 25, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |   |  |   |                                 |  |                                   |  |                                |
| 22b. SIGNATURE<br><u>Donald W. Mintzer</u>  |  |  |  | DEGREE  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                 | 22c. DATE SIGNED<br><u>April 25, 1968</u>  |                                   |  |                                |
| 22d. PHYSICIAN'S NAME (Type)<br>Dr. Donald Mintzer  |  |  |  | 22e. ADDRESS<br>3009 Evergreen Ave  |  |   |                                 | 21016  |                                   |  |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)  |                                 | (County)   |                                   | (State)                                      |                                |
| Burial  |  | 4-29-68  |  | Glen Haven  |  | Glen Burnie, Md.  |                                 |  |                                   |  |                                |
| 24. FUNERAL DIRECTOR<br><u>Curtis E. Evans</u>  |  |  |  | ADDRESS<br>1400 S. Charles St/ 21230  |  | 25a. REC'D BY REGISTRAR<br>DATE   |                                 | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |                                   | APR 26 1968                                  |                                |

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1. *Journal of the American Medical Association*, 1997; 277: 1025-1030.

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

Figure 1. Schematic representation of the experimental design. The subjects were divided into two groups: the control group and the experimental group. The control group received a standard diet, while the experimental group received a diet supplemented with 0.5% of the active ingredient. The subjects were then subjected to a 12-week period of physical training. The results of the study are presented in the form of a bar chart, showing the mean values and standard deviation for each group.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| 05336  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |  |  | 05338  |  |  |  |  |   |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH   |  |  |  |  |   |  |  |  |  | 2b. HOUR                                     |  |  |  |  |   |  |  |  |  |
| First Middle Last<br>Walter Niblett Parrish  |  |  |  |  |  |  |  |  |  | Month Day Year<br>April 30 1968   |  |  |  |  |   |  |  |  |  | 11 P M                                       |  |  |  |  |   |  |  |  |  |
| 3. SEX<br>Male   |  |  |  |  | 4. RACE<br>White   |  |  |  |  | 5. DATE OF BIRTH<br>Feb. 5, 1916  |  |  |  |  | 6. AGE (In years last birthday)<br>52 YRS.  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS               |  |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN                                   |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Baltimore, Md.  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>Baltimore Co. Md.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore, Md.  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>6710 Brighton Ave. |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Engineer   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Penn-Central   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  |  |  |  | 13b. COUNTY<br>Baltimore   |  |  |  |  | 13c. CITY OR TOWN<br>Baltimore-15   |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br>6710 Brighton Ave. |  |  |  |  |   |  |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Walter Clem Parrish  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Ethel Boyle                                       |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, oo, or unknown) (If yes give war or dates of service)<br>ies W.W. 11                                   |  |  |  |  |   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>215-07-6523      |  |  |  |  | 17. INFORMANT<br>Mrs. Roberta Oliff Parrish, 6710 Brighton Ave. |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Coronary occlusion<br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4201 |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hour<br>1 year  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                       |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 50, to April 19 68, that (I) (we) lost saw the deceased alive on April 24, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE<br>Millard T. Traband, Jr.   |  |  |  |  |   |  |  |  |  | 22c. DATE SIGNED<br>3 May 1968               |  |  |  |  |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Millard T. Traband, Jr. M.D.   |  |  |  |  | 22e. ADDRESS<br>1811 N. Rolling Rd. Balt. Md. 21207  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  |  |  | 23b. DATE<br>May 4, 1968   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park Cemetery  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Woodlawn Baltimore, Md.                        |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Frank H. Newell, Pikesville, Md.   |  |  |  |  | 25a. REC'D BY REGISTRAR<br>MAY 7 1968  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |

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FOR STATE  
HEALTH DEPT

05337

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05339

|  |                  |   |   |   |  |   |  |   |  |                        |  |                          |
|--|------------------|---|---|---|--|---|--|---|--|------------------------|--|--------------------------|
| 1. DECEASED-NAME<br>(Type or Print) <b>LILLIAN E. PATRICK</b>  |                  |   | First Middle Last   |   |  | 2a. DATE KNOWN OF DEATH ESTI- MATED <b>4-20</b> 19 <b>68</b>                            |  |   |  | 2b. HOUR <b>11-A</b> M |  |                          |
| 3. SEX <b>F</b>  | 4. RACE <b>W</b> | 5. DATE OF BIRTH <b>10/23/1912</b>      | 6. AGE (In years last birthday) <b>55</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD <b>4-20-68</b>                         |  |                        |  | 2d. HOUR <b>5:45</b> P M |
| 7a. BIRTHPLACE (State or foreign country) <b>MD</b>  |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>BALTO.</b>  |  |   |  |                        |  | Md.                      |
| 1d. CITY OR TOWN OF DEATH <b>ESSEX</b>   |                  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>BOX 77 GINWOOD LANE</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                        |  |                          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institutional. Residence before admission) STATE <b>MD.</b>   |                  |   | 13b. COUNTY <b>BALTO</b>  |   | 13c. CITY OR TOWN <b>ESSEX</b>                     |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER <b>BOX 77 GINWOOD LANE</b>                                |                        |  |                          |
| 14. FATHER'S NAME First Middle Last <b>THOMAS JONES</b>  |                  |   | 15. MOTHER'S MAIDEN NAME First Middle Last <b>MARIAN PILLING</b>  |   |  |   |  |   |  |                        |  |                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |                  |   | 16b. SOCIAL SECURITY NO. <b>213-20-7091</b>   |   | 17. INFORMANT ADDRESS <b>CARL N. PATRICK SR.</b>   |   |  |   |  |                        |  |                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>A-S C-V-DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4221</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |                  |   |   |   |  |   |  |   |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>DIABETES MELLITUS</b>   |                  |   |   |   |  |   |  |   |  |                        |  |                          |
| 19a. DATE OF OPERATION   |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |   |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                        |  |                          |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                  |   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>19</b>  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |   |  |                        |  |                          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                  |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                            |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |  |   |  |                        |  |                          |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>M.B. Davis</b> 6800 M.D.<br>EXAMINER'S NAME (Type) <b>M.B. DAVIS MORNINGTOWN RD</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>22b. DATE SIGNED <b>4/20/68</b><br>ADDRESS (Street, city, town, or county) |                  |   |   |   |  |   |  |   |  |                        |  |                          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |                  |   | 23b. DATE <b>4/23/68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD</b> |   |  | 23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b> |  |                        |  |                          |
| 24. FUNERAL DIRECTOR <b>J.G. CONNELLY SONS</b> ADDRESS <b>300 MACE</b>   |                  |   |   |   |  | 25a. REC'D BY REGISTRAR <b>APR 24 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                 |  |                        |  |                          |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |         |   |                                    |   |                            |   |                        |  |      |   |
|---|---------|---|------------------------------------|---|----------------------------|---|------------------------|--|------|---|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First   | Middle                             | Last  | 2a. DATE KNOWN<br>OF DEATH |   | Month                  | Day  | Year | 2b. HOUR  |
| ROY   |         | GLENWOOD  | PENNINGTON                         | 2a. DATE KNOWN<br>OF DEATH MATED <input checked="" type="checkbox"/>                  |                            | 4/29/   | 1968                   | 1  | PM   |   |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (In years<br>last birthday) | IF UNDER 1 YEAR<br>MONTHS   | IF UNDER 24 HRS<br>DAYS    | IF UNDER 24 HRS<br>HOURS  | IF UNDER 24 HRS<br>MIN | 2c. DATE PRONOUNCED DEAD   |      | 2d. HOUR  |
| male  | white   | Aug. 31, 1924   | 43 YRS                             |   |                            |   |                        | Month  | Day  | Year  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |                            | 9. COUNTY OF DEATH  |                        | 10. CITY OR TOWN OF DEATH  |      |   |
| West Va.  |         | U. S. A.  |                                    | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |                            | Baltimore   |                        | Dundalk  |      |   |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)   |         | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |                                    | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |                            | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE              |                        | 13b. CITY OR TOWN  |      | 13c. INSIDE CITY LIMITS?  |
| 7920 St. Gregory Drive  |         | Mechanic  |                                    | Bethlehem Steel   |                            | Maryland  |                        | Baltimore  |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 13d. STREET AND NUMBER  |         | 14. FATHER'S NAME   |                                    | 15. MOTHER'S MAIDEN NAME  |                            | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |                        | 16b. SOCIAL SECURITY NO.   |      | 17. INFORMANT (Wife)  |
| 7924 St. Geogoy Drive   |         | Stanford  |                                    | Pearl   |                            | Yes   |                        | 218-16-4411  |      | Mrs. Rosemary Pennington, 7920 St. Gregory Dr                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Shotgun Wound of Chest<br>955X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |         | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |                                    | 19a. DATE OF OPERATION  |                            | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |                        | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |      |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br>976X   |         | 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                                    | 21b. TIME OF INJURY Month, Day, Year<br>12:10 A.M. 4/29 19 68                         |                            | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Subject shot self in chest |                        | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |      |   |
| 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br>home   |         | 21f. LOCATION Street or R.F.D. No.  |                                    | City or Town  |                            | County  |                        | State  |      |   |
| Dundalk, Baltimore, Maryland  |         | 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                    | 22b. DATE SIGNED<br>4/29/68   |                            | 22c. REGISTRAR'S SIGNATURE<br>Charles Judge   |                        | 22d. REGISTRAR'S SIGNATURE   |      |   |
| ACTUAL<br>SIGNATURE<br>EXAMINER'S<br>NAME (Type)  |         | Werner u. Spita, M.D.   |                                    | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                       |                            | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                        | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |      |   |
| ADDRESS(Street, city, town, or county)  |         | 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |                                    | 23b. DATE   |                            | 23c. NAME OF CEMETERY OR CREMATORY  |                        | 23d. LOCATION (City or Town) (County) (State)  |      |   |
| Burial  |         | 5/2/68  |                                    | St. Stanislaus Cemetery   |                            | Baltimore, Md.  |                        | 24. FUNERAL DIRECTOR   |      |   |
| John J. Duda, 7922 Wise Ave. Dundalk, Md.   |         | 25a. REC'D BY REGISTRAR<br>DATE   |                                    | APR 30 1968   |                            | 25b. REGISTRAR'S SIGNATURE  |                        | Charles Judge  |      |   |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |         |   |  |  |  |   |  |   |  |   |      |   |          |      |          |
|--|---------|---|--|--|--|---|--|---|--|---|------|---|----------|------|----------|
| 1. DECEASED-NAME<br>(Type or Print)  |         | First   |  | Middle   |  | Last  |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED           |  | Month   | Day  | Year  | 2b. HOUR |      |          |
| HARRY  |         | W.  |  | PETERSON   |  |   |  | 4-12  |  | 68  | 11A. | M   |          |      |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                      |  | IF UNDER 24 HRS<br>HOURS MIN                        |  | 2c. DATE PRONOUNCED DEAD                                    |      | Month   | Day      | Year | 2d. HOUR |
| Male   | White   | Nov 8, 1919   |  | 48 YRS   |  |   |  |   |  | 4-12  |      | 68  | 3P.      | M    |          |
| 7a. BIRTHPLACE (State or foreign<br>country)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED   |  | NEVER MARRIED   |  | 9. COUNTY OF DEATH                                  |  |   |      |   |          |      |          |
| Ohio   |         | USA   |  | WIDOWED  |  | DIVORCED  |  | Baltimore   |  |   |      |   |          | Md.  |          |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                |  |   |  |   |      |   |          |      |          |
| Middle River   |         | 2207 Baker Ave.   |  | Mill Wright  |  | Aircraft  |  |   |  |   |      |   |          |      |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |         | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER                              |  |   |      |   |          |      |          |
| Maryland   |         | Baltimore   |  | Middle River   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 2207 Baker Ave.                                     |  |   |      |   |          |      |          |
| 14. FATHER'S NAME  |         | First   |  | Middle   |  | Last  |  | 15. MOTHER'S MAIDEN NAME                            |  | First   |      | Middle  |          | Last |          |
| Unknown  |         |   |  |  |  |   |  | Unknown   |  |   |      |   |          |      |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |         | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS   |  |   |  |   |      |   |          |      |          |
| Yes  |         | WWII  |  | 201 01 3894  |  | Margaret Thorpe   |  | 244 Thomas Dr. Del.                                 |  |   |      |   |          |      |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>A-S-C-V-Disease</u><br>4129<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |   |  |  |  |   |  |   |  |   |      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |          |      |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>4221  |         |   |  |  |  |   |  |   |  |   |      |   |          |      |          |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                            |  | 20. AUTOPSY?   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |   |  |   |      |   |          |      |          |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                    |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)            |  |   |  |   |  |   |      |   |          |      |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                               |  |   |  |   |  |   |      |   |          |      |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |   |  |  |  |   |  |   |  |   |      |   |          |      |          |
| ACTUAL<br>SIGNATURE  |         | M.B. Davis  |  | M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                     |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |      | 22b. DATE SIGNED<br>4/12/68                     |          |      |          |
| EXAMINER'S<br>NAME (Type)  |         | M.B. Davis, M.D.  |  | 6800 Morningside Rd.   |  | Baltimore, Md.  |  | 22c. ADDRESS (City, Town, County, State)            |  |   |      |   |          |      |          |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)                       |  |   |  |   |      |   |          |      |          |
| Burial   |         | 4/19/68   |  | Baltimore, National Cemetery   |  | Baltimore, Md.  |  |   |  |   |      |   |          |      |          |
| 24. FUNERAL DIRECTOR   |         | ADDRESS   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |   |      |   |          |      |          |
| James E. Bruzdziński   |         | 1407 Eastern Ave.   |  | APR 18 1968  |  | Charles Judge   |  |   |  |   |      |   |          |      |          |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-46-68 mt-1m 399. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |  |                           |  |   |  |
|--|--|--|--|---|--|---|--|--|---------------------------|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |                           |  |   |  |
| 1. DECEASED-NAME (Type or Print) <b>Robert Norman Peterson</b>   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month <b>4</b> Day <b>20</b> Year <b>1968</b> |  |  | 2b. HOUR <b>3:40</b> P.M. |  |   |  |
| 3. SEX <b>M</b>  |  | 4. RACE <b>W</b>   |  | 5. DATE OF BIRTH <b>6/21/50</b>   |  | 6. AGE (In years last birthday) <b>17</b> YRS.  |  | IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>  |                           | IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>        |   |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. COUNTY OF DEATH <b>Baltimore</b> Md.              |   |  |
| 10. CITY OR TOWN OF DEATH <b>Arbutus</b>   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>-</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Student</b>   |                           |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>School</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md.</b>   |  |  |  | 13b. COUNTY <b>-</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                           | 13e. STREET AND NUMBER <b>2211 Pelham Ave. 21213</b> |   |  |
| 14. FATHER'S NAME First <b>Robert G.</b> Middle <b>Peterson</b> Last <b>Peterson</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>Dolores</b> Middle <b>V.</b> Last <b>Tanski</b>     |  |   |  |  |                           |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>-</b>   |  | 17. INFORMANT <b>Mr. Robert G. Peterson</b>   |  |  |                           | ADDRESS <b>(Same)</b>                                |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxiation By Drowning</b><br><b>910.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  |   |  |  |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>9292</b>   |  |  |  |   |  |   |  |  |                           |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                     |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           |  |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY Month, Day, Year <b>4-20 19 68</b> HOURS <b>3:40</b> P.M.                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)       |  |   |  |  |                           |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Gravel Pit</b> |  | 21f. LOCATION Street or R.F.D. No. <b>Halethorne</b>                                  |  | City or Town <b>Baltimore</b>   |  | County <b>Baltimore</b>  |                           | State <b>Md.</b>                                     |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |   |  |   |  |  |                           |  |   |  |
| ACTUAL SIGNATURE <b>James N. Frederick</b>   |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                       |  |   |  | 22b. DATE SIGNED <b>4/20/68</b>  |                           |  |   |  |
| EXAMINER'S NAME (Type) <b>James N. Frederick md</b>  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                   |  |   |  | 1311 Loran Ave   |                           |  |   |  |
|  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                           |  |   |  | ADDRESS (Street, city, town, or county) <b>Balto. md. 21229</b>  |                           |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE <b>4/24/68.</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Crestlawn Gdns. of Memories</b>                 |  |   |  | 23d. LOCATION (City or Town) (County) (State) <b>West Friendship, Md.</b>  |                           |  |   |  |
| 24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Ba lto. Md. 21214</b>  |  |  |  | ADDRESS   |  |   |  | 25a. REC'D BY REGISTRAR <b>APR 22 1968</b>   |                           | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>        |   |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05343

|  |                      |  |  |  |  |  |  |   |   |  |  |
|--|----------------------|--|--|--|--|--|--|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>KARL Joseph PFAU</b>  |                      | First  |  | Middle   |  | Last   |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 4 17 1968 |   | 2b. HOUR ? M   |  |
| 3. SEX <b>Male</b>   | 4. RACE <b>White</b> | 5. DATE OF BIRTH <b>9-1-08</b>   |  | 6. AGE (In years last birthday) <b>59</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN  |   | 2c. DATE PRONOUNCED DEAD<br>Month 4 Day 20 Year 1968 2pm                         |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Germany</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>BALTIMORE</b> Md.  |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>615 Meadow Rd.</b> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Painter</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>None</b> |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>md.</b>   |                      | 13b. COUNTY <b>Balto</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 13e. STREET AND NUMBER <b>615 Meadow Rd.</b>                                    |   |  |  |
| 14. FATHER'S NAME <b>Joseph PFAU</b>   |                      | First  |  | Middle   |  | Last   |  | 15. MOTHER'S MAIDEN NAME <b>Christina</b>                                       |   | First Middle Last  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                      | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS <b>Eric M PFAU 1532 Latrobe Bk Terrace</b>                                       |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hanging - self inflicted.</b><br><b>953X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a): stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                      |  |  |  |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>undet.</b>                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>974X</b>   |                      |  |  |  |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |                      |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                      | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                      | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                      |  |  |  |  |  |  |   |   |  |  |
| ACTUAL SIGNATURE <b>John E. Hyle</b>   |                      | EXAMINER'S NAME (Type) <b>JOHN E. Hyle</b>   |  | M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                             |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                      |  |
|  |                      |  |  |  |  | 22b. DATE SIGNED <b>4-20-68</b>  |  | ADDRESS (Street, city, town, or county) <b>7527 Bureau Rd</b>                   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                      | 23b. DATE <b>4/22/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Garden of Faith</b>  |  | 23d. LOCATION (City or Town) <b>Balto Co. Md.</b>  |  | (County) (State)  |   |  |  |
| 24. FUNERAL DIRECTOR <b>Kassab Funeral Home</b>  |                      |  |  | ADDRESS <b>7401 Belair Rd.</b>   |  | 25a. REC'D BY REGISTRAR <b>APR 23 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                                 |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |                                 |   |   |   |  |  |                            |  |
|---|--|---|---------------------------------|---|---|---|--|--|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |                                 |   |   |   |  |  |                            |  |
| CERTIFICATE OF DEATH  |  |   |                                 |   |   |   |  |  |                            |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First Middle Last               |   |   | 2a. DATE OF DEATH   |  | 2b. HOUR                                     |                            |  |
| JOHN HEYWOOD PHILLIPS   |  |   |                                 |   |   | Month Day Year<br>APRIL 13 1968   |  | 4:10AM                                       |                            |  |
| 3. SEX  |  | 4. RACE   |                                 | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS               |                            |  |
| MALE  |  | WHITE   |                                 | APRIL 14, 1906  |   | 61 YRS.   |  | IF UNDER 24 HRS.<br>HOURS MIN.               |                            |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  | Md.  |                            |  |
| MARYLAND  |  | U.S.A.  |                                 |   |   | BALTIMORE   |  |  |                            |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)    |                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |                            |  |
| FORT HOWARD   |  | VETERANS ADMIN. HOSPITAL  |                                 | LITHOGRAPHER  |   | Crown Cork & Seal   |  |  |                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY   |                                 | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                       |                            |  |
| MARYLAND  |  | BALTIMORE   |                                 | BALTIMORE   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  | 617 48TH STREET                              |                            |  |
| 14. FATHER'S NAME   |  |   | 15. MOTHER'S MAIDEN NAME        |   |   | Address   |  |  |                            |  |
| First Middle Last<br>CHARLES H PHILLIPS   |  |   | First Middle Last<br>KATIE COLE |   |   |   |  |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)  |  |   | 16b. SOCIAL SECURITY NO.        |   | 17. INFORMANT   |   |  |  | Address                    |  |
| YES WWII  |  |   | 213 01 00 51                    |   | CLINICAL RECORDS, VA HOSP, FT HOWARD, MD  |   |  |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) LAENNEC'S CIRRHOSIS<br>571.0<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |                                 |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>3811  |  |   |                                 |   |   |   |  |  |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |                                 |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |                            |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                 | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |                            |  |
| 22a. I certify that (this hospital) attended the deceased from 11/27/67, 19, to 4/13/68, 19, that (we) last saw the deceased alive on 4/13/68, 19, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.  |  |   |                                 |   |   |   |  |  |                            |  |
| 22b. SIGNATURE<br>Chong Choon Han   |  |   |                                 |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>4 13 68  |  |                            |  |
| 22d. PHYSICIAN'S NAME (Type)<br>CHONG CHOON HAN, M.D.   |  |   |                                 |   | 22e. ADDRESS<br>VA HOSPITAL, FORT HOWARD, MARYLAND  |   |  |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE   |                                 | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |  |  |                            |  |
| BURIAL  |  | 4/16/68   |                                 | SACRED HEART CEMETERY   |   | GERMAN HILL RD, BALTIMORE, MD   |  |  |                            |  |
| 24. FUNERAL DIRECTOR  |  |   |                                 |   | ADDRESS   |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE |  |
| MORAN FUNERAL HOME, 3000 E BALTO ST, BALTO MD   |  |   |                                 |   |   |   | DATE APR 16 1968   |  | Charles Judge              |  |

DATE: APRIL 12, 1952

TO: THE DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [REDACTED]

RE: [REDACTED]

1. [REDACTED]

2. [REDACTED]

3. [REDACTED]

4. [REDACTED]

5. [REDACTED]

6. [REDACTED]

7. [REDACTED]

8. [REDACTED]

9. [REDACTED]

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

13. [REDACTED]

14. [REDACTED]

15. [REDACTED]

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-2. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05343

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05343

|   |                      |  |  |  |  |
|---|----------------------|--|--|--|--|
| 1. DECEASED NAME<br>(Type or Print) <b>MICHAEL JOSEPH PHILLIPS</b>  |                      |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2b. HOUR <input type="checkbox"/> MIN. <input type="checkbox"/> <b>APRIL 12, 1968</b> |  |  |
| 3. SEX <b>MALE</b>  | 4. RACE <b>WHITE</b> | 5. DATE OF BIRTH <b>SEPT. 29 1921</b>  | 6. AGE (In years last birthday) <b>46 YRS.</b>   | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> |
| 7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7204 CONLEY ST.</b>                |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>MACHINIST</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>MD</b>   |                      | 13b. COUNTY <b>BALTO</b>   |  | 13c. CITY OR TOWN <b>BALTO.</b>  |  |
| 14. FATHER'S NAME <b>FRANK PHILLIPS</b>   |                      | 15. MOTHER'S MAIDEN NAME <b>ANTOINETTE PAWLEK</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>AM. CAN CO</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>   |                      | 16b. SOCIAL SECURITY NO. <b>215-14-4034</b>  |  | 17. INFORMANT <b>MRS. VERA PHILLIPS</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-Vascular Disease</b><br><b>4120</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Disease</b>                                     |                      | 19a. DATE OF OPERATION <b>443X</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>None</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>443X</b>   |                      |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> <b>19</b> |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                      | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                      |  |  |  |  |
| ACTUAL SIGNATURE <b>M.B. Davis</b>  |                      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | 22b. DATE SIGNED <b>4/13/68</b>  |  |
| EXAMINER'S NAME (Type) <b>M.B. Davis M.D.</b>   |                      | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  | ADDRESS (Street, city, town, and county) <b>6800 MURKIN RD NEWTOWN</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                      | 23b. DATE <b>APRIL 16, 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS CEMETERY</b>  |  |
| 24. FUNERAL DIRECTOR <b>RAYMOND L. KACZOROWSKI</b>  |                      | ADDRESS <b>2525 FLEET ST.</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MD.</b>   |  |
| 25a. REC'D BY REGISTRAR <b>APR 17 1968</b>  |                      | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |  |  |

03830

03830



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05344  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05346

|  |  |   |  |   |  |   |   |   |  |
|--|--|---|--|---|--|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Bertha Winter Pile</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>17</b> Year <b>68</b> |   |  | 2b. HOUR<br><b>12:15 PM</b>   |   |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>4-28-28</b>  |  | 6. AGE (In years<br>lost birthday)<br><b>89</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                    |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>BALTO. Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTO.</b> Md.   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville Md.</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Shangri La Nursing Home Housewife</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before<br>admission) STATE <b>Md</b>   |  | 13b. COUNTY <b>BALTO</b>  |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>6100 Woodington Rd</b>   |  |
| 14. FATHER'S NAME First Middle Last<br><b>Louis Winter</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Bertha Roeder</b>  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-01-16231</b>   |  | 17. INFORMANT Address<br><b>Rose Loeffler 4401 Roland Ave</b>   |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Left Lower Lobe pneumonia</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cerebro-vascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>A.S.C.V.D.</b>   |  |   |  |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 month</b><br><b>1 month</b><br><b>years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221</b>  |  |   |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2 Apr 68</b> , 19 <b>68</b> , to <b>17 Apr</b> , 19 <b>68</b> , that (I) ( <del>we</del> ) last<br>saw the deceased alive on <b>12 Apr</b> , 19 <b>68</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the<br>causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death. |  |   |  |   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Ralph E. Updike MD</b> DEGREE ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>   |  |   |  |   |  | 22c. DATE SIGNED<br><b>17 Apr 68</b>  |   |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>Ralph E. Updike MD</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>31 Dogwood Drive</b>   |   |   |  |
| 23a. BURIAL, CREMATION,<br><b>CREMATION</b>  |  | 23b. DATE<br><b>4/20/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Crematory</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b>                      |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>HENRY SANDER &amp; SONS INC, BALTO. MD.</b>   |  |   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 22 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

0234

CERTIFICATE

0234

IN WITNESS WHEREOF, I have hereunto set my hand and seal of the said Court, at the City of New York, this 1st day of January, 1901.

NOTARY PUBLIC

JOHN J. HENRY

Subscribed and sworn to before me this 1st day of January, 1901.

JOHN J. HENRY



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VR A15 (4)  
30M REV. 1/68

1  
05345  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH  
05347

|  |  |   |  |   |  |   |  |   |  |                               |  |
|--|--|---|--|---|--|---|--|---|--|-------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Arthur C. Pinder  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>April 23 1968           |   |  | 2b. HOUR<br>7A M  |  |   |  |                               |  |
| SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>Oct. 8, 1885  |  | 6. AGE (In years last birthday)<br>82 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                |  | IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |  |                               |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Ridgeway Manor Nursing Home |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Guard  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Arcrods  |  |   |  |                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Dundalk  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>8221 Longpoint Road |  |                               |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Solomon Pinder   |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Fannie Knotts |   |  |   |  |   |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>216-03-6600   |  | 17. INFORMANT<br>Thomas Pinder, 8221 Longpoint Rd. Dundalk, Address Md. 21222   |  |   |  |   |  |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sleep apnea</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 week |  |   |  |   |  |   |  |   |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>05347  |  |   |  |   |  |   |  |   |  |                               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |                               |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |   |  |   |  |                               |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |   |  |   |  |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1967, to 530a, 1968, that (I) (we) last saw the deceased alive on 22 Apr 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |   |  |                               |  |
| 22b. SIGNATURE<br>William Goodman M.D.   |  |   |  |   |  |   |  |   |  | 22c. DATE SIGNED<br>21 Apr 68 |  |
| 22d. PHYSICIAN'S NAME (Type)<br>William Goodman  |  |   |  |   | 22e. ADDRESS<br>M.D. 1334 Sulphur Spring Rd. Baltimore, Md.                          |   |  |   |  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>4/26/68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial Park  |  |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland |   |  |                               |  |
| 24. FUNERAL DIRECTOR<br>John J. Duda, 7922 Wise Ave. Dundalk, Md.  |  |   |  |   | 25a. REC'D BY REGISTRAR<br>DATE APR 25 1968  |   | 25b. REGISTRAR'S SIGNATURE<br>Charles J. J. J.                       |   |  |                               |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05346

05348

|  |  |  |  |   |   |   |  |   |                                      |  |
|--|--|--|--|---|---|---|--|---|--------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>MILTON A PLATT</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>4</b> / Day <b>20</b> / Year <b>1968</b>                               |   |   | 2b. HOUR<br><b>4:45 PM</b>  |  |   |                                      |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>                    |  | 5. DATE OF BIRTH<br><b>1/31/89</b>  |   | 6. AGE (in years<br>lost birthday)<br><b>79</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                     |                                      |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>BALT.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALT</b> Md.   |  |   |                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>SHANGKILAN H.</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired)<br><b>MACHINIST</b> |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>MD.</b>  |  |  | 13b. COUNTY <b>BALTO</b>   |   |   | 13c. CITY OR TOWN<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                      |  |
| 14. FATHER'S NAME First Middle Last<br><b>MATHEW W PLATT</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>E. SCHMIDT</b>                                      |   |   |   |  |   |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><b>705-03-2512</b>   |   |   | 17. INFORMANT<br>Address <b>LOUIS PLATT 638 STAMFORD RD</b>   |  |   |                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>TERMINAL BRONCHOPNEUMONIA</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>ARTERIO SCLEROTIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>GENERALIZED ARTERIO SCLEROSIS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>18 months</b><br><b>years</b> |  |  |  |   |   |   |  |   |                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>4200</b>   |  |  |  |   |   |   |  |   |                                      |  |
| 19a. DATE OF OPERATION<br><b>—</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? <b>—</b>                |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                    |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>—</b>                   |  |   |                                      |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                      |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 20</b> , 1966, to <b>April 20</b> , 1968, that (I) (we) last saw the deceased alive on <b>April 20</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |   |                                      |  |
| 22b. SIGNATURE<br><b>Melvin N Borden MD</b> DEGREE <b>MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  |   |   | 22c. DATE SIGNED<br><b>4/20/68</b>  |  |   |                                      |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>MELVIN N. BORDEN M.D.</b>   |  |  |  |   |   | 22e. ADDRESS<br><b>5000 BALTO NAT'L PIKE, BALTO MD 21224</b>  |  |   |                                      |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>4-23-68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOXLEY PARK CEM.</b> |   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO MD</b> |   |                                      |  |
| 24. FUNERAL DIRECTOR<br><b>Weyer Funeral Home 5311 Edmondson Ave</b>   |  |  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 22 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                                      |  |

MEDICAL CERTIFICATION

8345

CERTIFICATE OF DESIGN

8345

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*

RECEIVED BY THE SECRETARY OF THE ARMY  
WASHINGTON, D. C. 20315  
JAN 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05347

05349

|  |  |   |  |   |  |  |  |   |                        |   |                            |  |  |
|--|--|---|--|---|--|--|--|---|------------------------|---|----------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print) <u>Julius</u>  |  | First   |  | Middle  |  | Last   |  | 2a. DATE OF DEATH<br>Month <u>APRIL</u> Day <u>18</u> Year <u>1968</u>                                    |                        |   | 2b. HOUR<br><u>4:00 PM</u> |  |  |
| 3. SEX<br><u>MALE</u>  |  | 4. RACE<br><u>WHITE</u>                       |  | 5. DATE OF BIRTH<br><u>JULY 17 1891</u>   |  |  |  | 6. AGE (In years last birthday)<br><u>76</u> YRS.   |                        | IF UNDER 1 YEAR<br>MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN.        |                            |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><u>GERMANY</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><u>BALTIMORE</u> Md.                       |  |   |                        |   |                            |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTO</u>  |  |   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>8025 Woodgate Ct</u>   |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>GROCEER</u> |                        | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>GROCEER</u>                         |                            |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>  |  |   |  | 13b. COUNTY<br><u>BALTO</u>   |  | 13c. CITY OR TOWN<br><u>BALTO</u>                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |                        | 13e. STREET AND NUMBER<br><u>8025 WOODGATE CT</u>                           |                            |  |  |
| 14. FATHER'S NAME First <u>DAVID</u> Middle <u>PLANT</u> Last <u>PLANT</u>   |  |   |  | 15. MOTHER'S MAIDEN NAME First <u>LINDA</u> Middle <u>PLANT</u> Last <u>PLANT</u>   |  |  |  |   |                        |   |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <u>NO</u> (If yes give war or dates of service)  |  |   |  | 16b. SOCIAL SECURITY NO.<br><u>214-18-0770</u>  |  | 17. INFORMANT<br><u>ALICE PLANT</u>                              |  |   | Address<br><u>SAME</u> |   |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br><u>436.9</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |   |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Days</u><br><u>Years</u> |                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>331X Arteriosclerotic Heart Disease</u>  |  |   |  |   |  |  |  |   |                        |   |                            |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |                        | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>19</u>   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                           |                        |   |                            |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                        |   |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 17, 1968</u> , to <u>April 18, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 17, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |                        |   |                            |  |  |
| 22b. SIGNATURE<br><u>David J. Miller</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |   |  |   |  |  |  | 22c. DATE SIGNED<br><u>4-18-68</u>  |                        |   |                            |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>David J. Miller</u>   |  |   |  |   |  |  |  | 22e. ADDRESS<br><u>9115 Reisterstown Rd. Owings Mills Md</u>  |                        |   |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  |   |  | 23b. DATE<br><u>APRIL 21, 1968</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cherry Avenue Chert</u> |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Randallstown Md</u>                                   |                        |   |                            |  |  |
| 24. FUNERAL DIRECTOR<br><u>Sylvan S. Lewis &amp; Son, Inc</u>  |  |   |  | ADDRESS<br><u>9115 Reisterstown Rd</u>  |  | 25a. REC'D BY REGISTRAR<br><u>DATE APR 22 1968</u>               |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |                        |   |                            |  |  |

10049

REPUBLIC OF DENMARK

10049

CHERRY 11111

2000 EDITION

10049



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|   |                              |   |   |  |  |   |   |  |      |
|---|------------------------------|---|---|--|--|---|---|--|------|
| 1. DECEASED-NAME<br>(Type or print)   |                              | First   | Middle  | Last   | 2a. DATE OF DEATH<br>Month Day Year  |   | 2b. HOUR  |  |      |
| Catherine Louise  |                              |   |   | PORTER   | April 11, 1968   |   | 9:30AM  |  |      |
| 3. SEX  | 4. RACE                      |   | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>lost birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |      |
| Female  | White                        |   | December 23, 1907   |  | 60 YRS.  |   | IF UNDER 24 HRS.<br>HOURS MIN.  |  |      |
| 7a. BIRTHPLACE (State or foreign<br>country)  | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |   |   |  |      |
| Maryland  | U.S.A.                       |   |   |  | Baltimore, Md.   |   |   |  |      |
| 10. CITY OR TOWN OF DEATH   |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |  |      |
| Towson  |                              | ST. JOSEPH HOSPITAL   |   | Homemaker  |  | Own Home  |   |  |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |                              | 13b. COUNTY   |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER                                 |      |
| Maryland  |                              | Lutherville   |   | Lutherville  |  |   |   | 1201 Longford Rd.                                      |      |
| 14. FATHER'S NAME   |                              | First   | Middle  | Last   | 15. MOTHER'S MAIDEN NAME   |   | First   | Middle   | Last |
| Edward J. Naughton  |                              |   |   |  | Francis Gravenstein  |   |   |  |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no or unknown) (If yes give year or dates of service)  |                              | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT Address  |  |   |   |  |      |
| No  |                              | None  |   | Fred W. Porter, 1201 Longford Rd., Lutherville   |  |   |   |  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple pulmonary emboli</u><br><u>430.9</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Intra-cranial hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Ruptured congenital saccular aneurysm of the anterior cerebral artery.</u><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                              |   |   |  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>Md. |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><u>230x</u>   |                              |   |   |  |  |   |   |  |      |
| 19a. DATE OF OPERATION  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)            |  |   |   |  |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No.   |  | City or Town  |   | County State   |      |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>3/12/</u> , 19 <u>68</u> , to <u>4/11/</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>4/11/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                              |   |   |  |  |   |   |  |      |
| 22b. SIGNATURE  |                              | 22c. DATE SIGNED  |   | 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS  |   | 22f. ADDRESS   |      |
| <u>Lawrence F. Misanik</u>  |                              | April 11, 1968  |   | Lawrence F. Misanik, M.D.  |  | 7620 York Rd., Towson, Md. 21204  |   | 7620 York Rd., Towson, Md. 21204                       |      |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |                              | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |   | 23e. LOCATION (City or Town) (County) (State)          |      |
| Burial  |                              | Apr. 15, 1968   |   | Dulaney Valley Memorial  |  | Cockeysville, Maryland  |   | Cockeysville, Maryland                                 |      |
| 24. FUNERAL DIRECTOR  |                              | ADDRESS   |   | 25a. REC'D BY REGISTRAR  |  | 25b. REC'D BY REGISTRAR   |   | 25c. REC'D BY REGISTRAR                                |      |
| John Burns' Sons, Towson, Maryland  |                              |   |   | DATE APR 17 1968   |  | DATE APR 17 1968  |   | DATE APR 17 1968                                       |      |

WESCH

STATE OF MICHIGAN

1888

IN SENATE,  
January 10, 1888.  
REPORT  
OF THE  
COMMISSIONER OF THE  
LAND OFFICE,  
FOR THE YEAR  
1887.  
LANSING:  
W. B. BECK & CO. PRINTERS,  
1888.

THE LAND OFFICE  
OF THE STATE OF MICHIGAN,  
HAS THE HONOR TO ANNOUNCE  
THAT THE FOLLOWING  
LANDS HAVE BEEN  
ACQUIRED BY THE STATE  
DURING THE YEAR  
1887:

1. A certain tract of land  
situated in the township of  
... county of ...  
containing ... acres,  
was acquired by the state  
by purchase from ...  
for the sum of ... dollars.  
2. A certain tract of land  
situated in the township of  
... county of ...  
containing ... acres,  
was acquired by the state  
by purchase from ...  
for the sum of ... dollars.  
3. A certain tract of land  
situated in the township of  
... county of ...  
containing ... acres,  
was acquired by the state  
by purchase from ...  
for the sum of ... dollars.  
4. A certain tract of land  
situated in the township of  
... county of ...  
containing ... acres,  
was acquired by the state  
by purchase from ...  
for the sum of ... dollars.  
5. A certain tract of land  
situated in the township of  
... county of ...  
containing ... acres,  
was acquired by the state  
by purchase from ...  
for the sum of ... dollars.  
6. A certain tract of land  
situated in the township of  
... county of ...  
containing ... acres,  
was acquired by the state  
by purchase from ...  
for the sum of ... dollars.  
7. A certain tract of land  
situated in the township of  
... county of ...  
containing ... acres,  
was acquired by the state  
by purchase from ...  
for the sum of ... dollars.  
8. A certain tract of land  
situated in the township of  
... county of ...  
containing ... acres,  
was acquired by the state  
by purchase from ...  
for the sum of ... dollars.  
9. A certain tract of land  
situated in the township of  
... county of ...  
containing ... acres,  
was acquired by the state  
by purchase from ...  
for the sum of ... dollars.  
10. A certain tract of land  
situated in the township of  
... county of ...  
containing ... acres,  
was acquired by the state  
by purchase from ...  
for the sum of ... dollars.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |  |  |
| WESTRY   |  |  | BURNETT  |  |  | POWELL   |  |  | Month Day Year 4 25 68 3:25A M                                       |  |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (In years lost birthday)                                      |  |  |
| MALE   |  |  | Colored  |  |  | 6/10/07  |  |  | 60 YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH   |  |  |
| NORTH CAROLINA   |  |  | U.S.A.   |  |  |  |  |  | BALTIMORE COUNTY Md.   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| FORT HOWARD  |  |  | VET. ADM. HOSPITAL   |  |  | INSURANCE AGENT  |  |  | Ins. Company   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS?   |  |  |
| STATE MARYLAND   |  |  |  |  |  | BALTIMORE  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  |
| First Middle Last  |  |  | First Middle Last  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> WW II  |  |  | 217 05 77 42   |  |  |
| MOSES POWELL   |  |  | Cora.  |  |  |  |  |  |  |  |  |
| 17. INFORMANT  |  |  | Address  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |  |
| CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.   |  |  |  |  |  | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA  |  |  |  |  |  |
|  |  |  |  |  |  | 185X DUE TO, OR AS A CONSEQUENCE OF CARCINOMA OF PROSTATE  |  |  |  |  |  |
|  |  |  |  |  |  | (b) DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |
|  |  |  |  |  |  | (c)  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  |  |  |
| 177X   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
|  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | YES  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |
|  |  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION  |  |  | City or Town County State  |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  | Street or R.F.D. No.   |  |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 3/10/68, 19__, to 4/25/68, 19__, that (H) (we) last saw the deceased alive on 4/25/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  | DEGREE   |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |  |  | 22c. DATE SIGNED   |  |  |
|  |  |  |  |  |  |  |  |  | 4/25/68  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  | 22e. ADDRESS   |  |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  | 23b. NAME OF CEMETERY OR CREMATORY                                   |  |  |
| Howard C. Kramer, M.D.   |  |  | VAH FORT HOWARD, MARYLAND  |  |  | BURIAL   |  |  | BALTIMORE NATIONAL   |  |  |
| 23c. BURIAL, CREMATION, REMOVAL (Specify)  |  |  | 23d. LOCATION (City or Town) (County) (State)                                |  |  | 23e. REC'D BY REGISTRAR  |  |  | 23f. REGISTRAR'S SIGNATURE   |  |  |
| 4-30-68  |  |  | BALTIMORE, MARYLAND  |  |  | APR 26 1968  |  |  | James Judge  |  |  |
| 24. FUNERAL DIRECTOR   |  |  | 25a. ADDRESS   |  |  | 25b. REC'D BY REGISTRAR  |  |  | 25c. REGISTRAR'S SIGNATURE   |  |  |
|  |  |  | ELOY O. WILSON FUNERAL HOME  |  |  | APR 26 1968  |  |  | James Judge  |  |  |
|  |  |  | ORLEANS STREET, BALTIMORE, MARYLAND  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |   |   |  |  |  |   |  |
|---|--|---|---|---|---|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |   |   |  |  |  |   |  |
| CERTIFICATE OF DEATH  |  |   |   |   |   |   |  |  |  |   |  |
| 05352   |  |   |   |   |   |   |  |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <i>LAWRENCE</i>   |  |   | First <i>STEWART</i> Middle <i>PRICE</i> Last                           |   |   | 2a. DATE OF DEATH<br><i>April</i> Month <i>28</i> Day <i>1968</i> Year                          |  | 2b. HOUR<br><i>11:35 A</i> M                                     |  |   |  |
| 3. SEX<br><i>MALE</i>   |  | 4. RACE<br><i>WHITE</i>   |   | 5. DATE OF BIRTH<br><i>11-3-19</i>  |   | 6. AGE (In years last birthday)<br><i>48</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Harrisonville Md</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Balto.</i>   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Randallstown</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Balto. Co. General</i> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>C.P.A.</i>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Accounting</i>  |  |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>   |  | 13b. COUNTY<br><i>Balto.</i>  |   | 13c. CITY OR TOWN<br><i>Randallstown</i>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>10005 Oak Glen Road</i>             |  |   |  |
| 14. FATHER'S NAME<br>First <i>Thomas</i> Middle <i>L.</i> Last <i>Price.</i>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First <i>Ethel</i> Middle <i>Benny</i> Last |   |   |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <i>NO</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>215-03-3386</i>  |   | 17. INFORMANT<br><i>Mrs. Rosalie E. Price</i> Address <i>10005 Oak Glen Road Randallstown, Md</i>   |   |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>4109</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4201</i><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |   |   |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>12 hr.</i> |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4-16</i> , 19 <i>68</i> , to <i>4-18</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4-18</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Daniel Bakal MD</i>  |  | DEGREE  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |   | 22c. DATE SIGNED<br><i>4-28-68</i>  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>DANIEL BAKAL, MD</i>   |  | 22e. ADDRESS<br><i>3600 LOCKHART DR</i>   |   |   |   |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 23b. DATE<br><i>5-1-68</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Ward's Chapel</i>  |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Balto. Md</i>                               |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>Henry Byers Rites SLS &amp; Subly Rd.</i>  |  |   |   | ADDRESS   |   | 25a. REC'D BY REGISTRAR<br>DATE <i>MAY 01 1968</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>               |  |   |  |

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STATE OF NEW YORK

THE STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
ALBANY, N. Y.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |   |  |  |  |   |  |   |  |                                |                            |  |  |
|---|--|--|---|--|--|---|--|--|--|---|--|---|--|--------------------------------|----------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |   |  |  |  |   |  |   |  |                                |                            |  |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |  |   |  |   |  |                                |                            |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><b>MARGARET</b>  |  |  | Middle<br><b>DALE</b>   |  |  | Last<br><b>PRICE</b>   |   |  | 2a. DATE OF DEATH<br><b>4/2/68</b> Month Day Year     |  |                                | 2b. HOUR<br><b>5:15</b> PM |  |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>White</b>   |  |  | 5. DATE OF BIRTH<br><b>July 2, 1874</b>   |  |  | 6. AGE (In years<br>lost birthday)<br><b>93</b> YRS.                                 |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                        |  | IF UNDER 24 HRS.<br>HOURS MIN. |                            |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Penna.</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>   |   |  | Md.   |  |                                |                            |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lutherville</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>College Manor</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Housewife</b>  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>HOME</b>                                  |   |  |   |  |                                |                            |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Balto.</b>  |  |  | 13c. CITY OR TOWN<br><b>Woodbrook</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  | 13e. STREET AND NUMBER<br><b>6425 Murray Hill Rd.</b> |  |                                |                            |  |  |
| 14. FATHER'S NAME First<br><b>William</b>   |  |  | Middle<br><b>Henry</b>  |  |  | Last<br><b>Harrison</b>   |  |  | 15. MOTHER'S MAIDEN NAME First<br><b>Anna</b>  |   |  | Middle<br><b>Dale</b>                                 |  |                                | Last<br><b>Beaver</b>      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>220-44-3876</b>  |  |  | 17. INFORMANT :daughter<br><b>Mrs. Emily P. Richardson</b>  |  |  | Address <b>Balto.-21212</b><br><b>6425 Murray Hill</b>                               |   |  |   |  |                                |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4109</b> <i>Coronary occlusion</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) <i>Arterio Sclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Chronic Ischemic Disease</i> |  |  |   |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |   |  |                                |                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>4201</b> <i>Similarity</i>   |  |  |   |  |  |   |  |  |  |   |  |   |  |                                |                            |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?              |   |  |   |  |                                |                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |   |  |                                |                            |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                         |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |   |  |                                |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 195</b> , 19 <b>66</b> , to <b>Apr 2</b> , 19 <b>68</b> , that (I) (we) last<br>saw the deceased alive on <b>Apr 2</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |  |   |  |   |  |                                |                            |  |  |
| 22b. SIGNATURE<br><i>W. P. Byerly MD</i>  |  |  | DEGREE<br><b>MD</b>   |  |  | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>                    |  |  | 22c. DATE SIGNED<br><b>4/3/68</b>  |   |  |   |  |                                |                            |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>M Paul Byerly</b>   |  |  | 22e. ADDRESS<br><b>5820 York Rd Balto MD</b>  |  |  |   |  |  |  |   |  |   |  |                                |                            |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>April 5, 1968</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville, Balto. Co., Md.</b>  |   |  |   |  |                                |                            |  |  |
| 24. FUNERAL DIRECTOR<br><b>STEWART &amp; MOWEN CO.</b>  |  |  | ADDRESS<br><b>108 W. North Av., Balto.</b>  |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 4 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                     |   |  |   |  |                                |                            |  |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                  |  |   |  |   |  |  |   |                                  |  |       |
|---|--|------------------|--|---|--|---|--|--|---|----------------------------------|--|-------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |   |  |   |  |  |   |                                  |  |       |
| 1. DECEASED-NAME (Type or Print)  |  |                  | First<br>NEAL  |   |  | Middle<br>EVANS   |  |  | Last<br>PRYNE   |                                  |  |       |
| 3. SEX<br>Male  |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>Dec 26, 1897                  |  | 6. AGE (In years last birthday)<br>77 70 RS   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  |   | IF UNDER 24 HRS.<br>HOURS<br>MIN |  |       |
| 7a. BIRTHPLACE (State or foreign country)<br>Virginia   |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore   |                                  |  |       |
| 10. CITY OR TOWN OF DEATH<br>Essex (21)   |  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>1432 Galena Road |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br>Seaman Ship Captain   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Merchant Marine  |                                  |  |       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  |                  | 13b. COUNTY<br>Baltimore   |   |  | 13c. CITY OR TOWN<br>Essex  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  | 13e. STREET AND NUMBER<br>1432 Galena Road   |       |
| 14. FATHER'S NAME<br>First<br>Unknown   |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Unknown  |  |  |   |                                  |  |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>Yes   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>WW1<br>086 12 8529    |  | 17. INFORMANT<br>ADDRESS<br>James Pine 24 Penna. Ave Towson, Md. 21204  |  |  |   |                                  |  |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4120 ① A-S + Hypertensive @-V-Disease -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                  |  |   |  |   |  |  |   |                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>443X Obesity -   |  |                  |  |   |  |   |  |  |   |                                  |  |       |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                                  |  |       |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                                     |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |                                  |  |       |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                     |   |  | 21f. LOCATION Street or R.F.D. No.  |  |  | City or Town  |                                  | County                                       | State |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |                  |  |   |  |   |  |  |   |                                  |  |       |
| ACTUAL SIGNATURE<br>M.B. Davis  |  |                  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  | 22b. DATE SIGNED<br>4-9-68  |                                  |  |       |
| EXAMINER'S NAME (Type)<br>M. B. Davis, M.D. 6800 Mornington Rd. Baltimore, Md. 21222  |  |                  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                     |                                  |  |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                  | 23b. DATE<br>4/16/68   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md. Roanoke, Va.                    |                                  |  |       |
| 24. FUNERAL DIRECTOR<br>Bruzdzinski Funeral Home 1407 Eastern Ave.  |  |                  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE APR 16 1968   |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |                                  |  |       |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-14  
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|
| 05353   |  | 05355   |  |  |  |  |  |   |  |
| 1. DECEASED-NAME (Type or print) <i>Joseph Woodley</i>  |  | First <i>QUEEN</i>  |  | 2a. DATE OF DEATH<br>4 Month 1 Day 1968  |  | 2b. HOUR<br>7:30 PM  |  |   |  |
| 3. SEX<br><i>M</i>  |  | 4. RACE<br><i>C</i>   |  | 5. DATE OF BIRTH<br>4-27-1913  |  | 6. AGE (In years lost birthday)<br>54 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Baltimore County, Md.</i>   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Mt. Wilson</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Mt. Wilson State Hosp.</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Farmhand</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>  |  | 13b. COUNTY <i>St. Mary's</i>   |  | 13c. CITY OR TOWN <i>Loverville</i>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                                  |  |
| 14. FATHER'S NAME First <i>John</i> Middle <i>George</i> Last <i>Queen</i>  |  | 15. MOTHER'S MAIDEN NAME First <i>Effie</i> Middle <i>Lammerville</i> Last                                    |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>220-16-8249</i>  |  | 17. INFORMANT Address<br><i>Records, Mt. Wilson State Hospital</i>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma of Esophagus &amp; Upper mediastinum</i><br>150 X DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>199.2</i> |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |
| 19a. DATE OF OPERATION<br><i>199.2</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>              |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-22, 1968</i> , to <i>4-1, 1968</i> , that (I) (we) last saw the deceased alive on <i>4-1-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>W. Newcomer</i>  |  | DEGREE<br><i>M.D.</i>   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22c. DATE SIGNED   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>William Newcomer, M.D.</i>   |  | 22e. ADDRESS<br><i>Mount Wilson, Maryland</i>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>  |  | 23b. DATE<br><i>APRIL 6, 1968</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>ST. JOSEPH'S CEMETERY</i>   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>MORGANZA, ST. MARY'S, MARYLAND</i>       |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>McLure Mattingly Leonard, Md.</i>  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE <i>APR 8 - 1968</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |   |  |

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RECEIVED 12 APR 1968

00328

APR 12 1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 05354  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |  |  |  |  | 05356                       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Item 5 Film G399 4/17/68   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  | First Middle Last  |  |  |  |  | 2a. DATE OF DEATH<br>Month Day Year  |  |  |  |  | 2b. HOUR<br>M   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Harry James Quick  |  |  |  |  |  |  |  |  |  | April 6, 1968  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  |  |  |  | 4. RACE  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  | 6. AGE (In years last birthday)   |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  | IF UNDER 24 HRS. HOURS MIN.            |  |  |  |  |  |  |  |  |  |
| Male   |  |  |  |  | Caucasian  |  |  |  |  | May 6, 1968 1878   |  |  |  |  | 89 YRS.   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Md.  |  |  |  |  | U.S.A.   |  |  |  |  |  |  |  |  |  | Baltimore   |  |  |  |  | Md.                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Woodlawn, Md.  |  |  |  |  | 2104 Park Pl.  |  |  |  |  | Florist  |  |  |  |  | Floral  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Md.  |  |  |  |  | Baltimore  |  |  |  |  | Woodlawn   |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  |  |  |  | 2104 Park Pl.               |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| David Taylor   |  |  |  |  | Emma Franklin  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown (If yes give war or dates of service)   |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT Address  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| No   |  |  |  |  | 218-32-4791  |  |  |  |  | Mrs. Ruth H. Quick-wf. 2104 Park Pl. 21207   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Vascular Accident</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 24 hrs  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 4129 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| (b) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| (c)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 4221 <u>PERNICIOUS ANEMIA</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 2 yrs.  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/7, 1966, to 4/6, 1968, that (I) (we) last saw the deceased alive on 4/6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE Joseph S. Blum DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED 4/8/68   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS 1115 N. CALVERT ST.  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)                                     |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Burial   |  |  |  |  | 4/9/68   |  |  |  |  | Loudon Park Cem.   |  |  |  |  | Baltimore, Md.  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE APR 11 1968  |  |  |  |  |                             |  |  |  |  | 25b. REGISTRAR'S SIGNATURE [Signature] |  |  |  |  |  |  |  |  |  |
| Wm. Cook-Brooks, West 6212 Balto. Nat'l. pike  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                              |  |  |                                     |  |  |  |                        |  |
|---|--|------------------------------|--|--|-------------------------------------|--|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                              |  |  |                                     |  |  |  |                        |  |
| CERTIFICATE OF DEATH  |  |                              |  |  |                                     |  |  |  |                        |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |                              | First Middle Last  |  |                                     | 2a. DATE OF DEATH  |  | 2b. HOUR   |                        |  |
| Robert Frederick RADTKE   |  |                              |  |  |                                     | Month 4 Day 28 Year 68   |  | 9:00 <sup>a</sup> M  |                        |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH   |                                     | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR  |                        |  |
| Male  |  | White                        |  | 10/16/31   |                                     | 36 YRS.  |  | MONTHS DAYS HOURS MIN  |                        |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. COUNTY OF DEATH   |  |  |                        |  |
| Maryland  |  | U.S.A.                       |  |  |                                     | Baltimore Md.  |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                     | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                        |  |
| Owings Mills  |  |                              | Rosewood State Hospital  |  |                                     | Dependent  |  | none   |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN                   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER |  |
| Maryland  |  |                              | Prince George  |  | Takoma Park                         |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | -                      |  |
| 14. FATHER'S NAME   |  |                              | 15. MOTHER'S MAIDEN NAME   |  |                                     |  |  |  |                        |  |
| First Middle Last   |  |                              | First Middle Last  |  |                                     |  |  |  |                        |  |
| Unknown   |  |                              | Unknown  |  |                                     |  |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address               |  |  |  |                        |  |
| no  |  |                              | none   |  | Rosewood Records, Owings Mills, Md. |  |  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                              |  |  |                                     |  |  |  |                        |  |
| PART 1. DEATH WAS CAUSED BY:  |  |                              |  |  |                                     |  |  |  |                        |  |
| IMMEDIATE CAUSE (a) Bilateral Orthostatic Necrotizing Pneumonia 2 wks   |  |                              |  |  |                                     |  |  |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |                              |  |  |                                     |  |  |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |                              |  |  |                                     |  |  |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |                              |  |  |                                     |  |  |  |                        |  |
| 52X Mangeloid status with severe mental retardation 36 yrs.   |  |                              |  |  |                                     |  |  |  |                        |  |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                     | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |                                     | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                     | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |                        |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 12/9, 19 36, to 4/28, 19 68, that (X) (we) lost saw the deceased alive on 4/28, 19 68, and that in (our) opinion death occurred on the date and hour and from the causes stated above; (X) (we) did (not) view the body after death. |  |                              | 22b. SIGNATURE Richard A. Jones  |  |                                     | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED 4/30/68   |                        |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |                              | 22e. ADDRESS   |  |                                     |  |  |  |                        |  |
| Richard A. Jones, M.D.  |  |                              | Rosewood St. Hosp., Owings Mills, Md.  |  |                                     |  |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |                        |  |
| Burial  |  |                              | May 2, 68  |  | Rosewood Cemetery                   |  | Owings Mills   |  |                        |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |                              |  |  | 25a. REC'D BY REGISTRAR             |  | 25b. REGISTRAR'S SIGNATURE   |  |                        |  |
| J. F. Eline & Sons Reisterstown, Md.  |  |                              |  |  | DATE MAY 6 1968                     |  | Charles Judge  |  |                        |  |

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2002-2003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

|  |  |  |  |   |   |   |  |   |  |  |  |
|--|--|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>PHYLLIS LUCINDA RANDOLPH</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>29</b> Year <b>1968</b>                     |   |   | 2b. HOUR<br><b>9:15 P M</b>   |  |   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>NEGRO</b>  |  | 5. DATE OF BIRTH<br><b>3/3/30</b>   |   | 6. AGE (In years last birthday)<br><b>38</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                    |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore County</b> Md.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mt. Wilson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Wilson State Hospital</b> |  |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                 |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTI.</b>   |  | 13c. CITY OR TOWN<br><b>BALTI.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  | 13e. STREET AND NUMBER<br><b>12 N. MORLEY ST.</b> |  |  |  |
| 14. FATHER'S NAME<br>First <b>JOSEPH</b> Middle <b>ALLEN</b> Last <b>WILKENS</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>ESTELLA</b> Middle <b>WILKENS</b> Last <b>WILKENS</b> |   |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-26-0428</b>   |  | 17. INFORMANT<br>Address <b>Records, Mt. Wilson State Hospital</b>  |   |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASPHYXIA DUE TO AIRWAY OBSTRUCTION</b><br><b>519.2</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PULMONARY HEMORRHAGE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <b>BACTEREMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Multiple abscesses and Fungus Ball</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>527.2</b> |  |  |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                     |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |   |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/28</b> , 19 <b>68</b> , to <b>4/29</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>4/29</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>W. Newcomer</b>   |  |  |  |   |   |   |  |   |  | 22c. DATE SIGNED                             |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William Newcomer, M.D.</b>  |  |  |  |   | 22e. ADDRESS<br><b>Mount Wilson, Maryland 21112</b>                       |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>5-4-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Arbutus Md.</b>   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Geo. F. Kelson 1348 N. Calhoun St</b>   |  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>MAY 1 1968</b>                         |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |   |  |  |  |

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Vertical text on the right margin, possibly a date or reference number.





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VR A15 (4)  
30M REV. 4-56

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 05357   |  | 05359  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First Middle Last  |  |
| WILLIAM STANLEY RAU   |  |  |  |
| 2. DATE OF DEATH  |  | Month Day Year   |  |
| April 12, 1968  |  |  |  |
| 3. SEX  |  | 4. RACE  |  |
| Male  |  | White  |  |
| 5. DATE OF BIRTH  |  | 6. AGE (In years lost birthday)  |  |
| May, 3, 1905  |  | 62 RS.   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |
| West Virginia   |  | USA  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. COUNTY OF DEATH   |  |
|   |  | Baltimore Md.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)                 |  |
| Towson  |  | St. Joseph Hospital  |  |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Plater- Self Emp  |  | Plating  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  |
| Maryland  |  | Baltimore  |  |
| 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 1011 Upnor Rd. 21212  |  |  |  |
| 14. FATHER'S NAME First Middle Last   |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |  |
| ? ?   |  | ?  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |  |
| No  |  | 212093677  |  |
| 17. INFORMANT Address   |  | Mrs. M. Loretta Rau- Same  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |
| IMMEDIATE CAUSE (a) Cerebro-Vascular Embolism   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| (b) Hemophlegia   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| (c) Atrial Fibrillation W/ Congestive Heart Failure   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |
| 4331  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
|   |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
|   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  |
|   |  |  |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
|   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                 |  |
|   |  |  |  |
| 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
|   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 27, 19 68, to April 12, 19 68, that (I) (we) last saw the deceased alive on April 12, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE Arturo Santos, M.D.  |  | 22c. DATE SIGNED April 12, 1968  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |
|   |  | 7620 York Rd., Towson, Md. 21204   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  |
| Burial  |  | 4/16/68  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |
| Gardens of Faith Cem  |  | Baltimore Co., Md.   |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  | 25a. REC'D BY REGISTRAR DATE   |  |
| Leonard J. Ruck Inc. 5305 Harford Rd.   |  | APR 15 1968  |  |
|   |  | 25b. REGISTRAR'S SIGNATURE Charles Judge   |  |

March 10, 1915

Washington, D.C.

Mr. J. L. ...

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 2nd inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,

Yours very truly,

...

Very truly yours,

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Very truly yours,

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Very truly yours,

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Very truly yours,

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Very truly yours,

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| Item 13 Film G400 5/2/68 kk CERTIFICATE OF DEATH 05360   |  |   |  |   |  |   |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Flora R. Reed  |  |   |  |   |  | 2a. DATE OF DEATH Month Day Year<br>4 25 68   |  | 2b. HOUR<br>4:20 PM  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>2/7/92  |  | 6. AGE (In years lost birthday)<br>76 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.           |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Spring Grove State Hospital |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Catonsville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>327 Harp Lane<br>Shangri-La Nursing Home   |  |
| 14. FATHER'S NAME First Middle Last<br>Louis C. Vogt   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Anna Naegel   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br>219-42-2009   |  | 17. INFORMANT Address<br>Records: Spring Grove State Hospital   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>4129<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>HEART FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ARTERIOSCLEROTIC HEART DISEASE</u><br>4200<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST: 4200 |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MIN<br>DAYS<br>YEARS |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>HIATAL HERNIA - UNDERVOUSH</u>  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/25/1968</u> , to <u>April 25 1968</u> , that (I) (we) last saw the deceased alive on <u>April 25 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE <u>Narciso Aristigueta</u> MD DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |   |  |   |  | 22c. DATE SIGNED<br>4-25-68   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>NARCISO ARISTIGUETA</u>  |  |   |  |   |  | 22e. ADDRESS<br>Spring Grove State Hospital   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  | 23b. DATE<br>4-29-1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br>Howard H. Hubbard, 4107 Wilkens Ave. 21229   |  |   |  |   |  | 25a. REC'D BY REGISTRAR<br>APR 26 1968 DATE   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                   |  |

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CHADIC ARREST

HEART FAILURE

ARTERIOLECTIC HEART DISEASE

HYDRA HERNIA - UNDER VENTILATION

4-22-68

MD

*W. H. H. H.*

ARISTIDEA

VR A15 DU  
MOM REV. 1/68

|  |  |   |  |   |  |  |  |  |                                      |   |  |   |  |
|--|--|---|--|---|--|--|--|--|--------------------------------------|---|--|---|--|
| 1. DECEASED NAME<br>(Type or print)  |  | First<br>GILBERT  |  | Middle<br>W.  |  | Last<br>REED   |  | 20. DATE OF DEATH<br>April Month 16 Day 1968 <sup>8</sup>            |                                      | 2b. HOUR<br>2:05 P.M.   |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>8-23-1894   |  |  |  | 6. AGE (In years<br>last birthday)<br>73 YRS.                        |                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md   |  |  |                                      |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Kensington  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>4306 Barrington Road |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Supervisor |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY |   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Kensington   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                     |  | 13e. STREET AND NUMBER<br>4306 Barrington Road                       |                                      |   |  |   |  |
| 14. FATHER'S NAME First Middle Last<br>James B. Reed   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Catherine Russell   |  |  |  |  |                                      |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)   |  | 16b. SOCIAL SECURITY NO.<br>212-01-5418A  |  | 17. INFORMANT Address<br>Mrs. Genevieve M. Reed, 4306 Barrington Rd.  |  |  |  |  |                                      |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u><br><u>185X</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 yr +</u> |  |   |  |   |  |  |  |  |                                      |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>177X</u>   |  |   |  |   |  |  |  |  |                                      |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                      |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |                                      |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |  | County   |                                      | State   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 9, 1968</u> , to <u>April 16, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 16, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |                                      |   |  |   |  |
| 22b. SIGNATURE<br><u>John A. Nesbitt, Jr.</u>  |  |   |  | 22c. DATE SIGNED<br>4-17-68   |  |  |  | 22d. PHYSICIAN'S NAME (Type)<br>Dr. John A. Nesbitt, Jr.             |                                      |   |  | 22e. ADDRESS<br>1009 Frederick Road, Catonsville, Md. |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  | 23b. DATE<br>4-20-1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland |                                      |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>Howard H. Hubbard, 4107 Wilkens Ave. 21229   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE APR 18 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |  |                                      |   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-7-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Annie Elizabeth Reeves   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>April 19, 1968              |   |  | 2b. HOUR<br>1:15 p.m.  |  |  |  |
| 3. SEX<br>female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>12/1/86   |  | 6. AGE (In years lost birthday)<br>81 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.           |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Balto., Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Spring Grove State Hospital |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Timonium   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>245 Coldbrook Road                               |  |
| 14. FATHER'S NAME First Middle Last<br>Robert A. Murray   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Elizabeth Washbourne |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>220-46-0623   |  | 17. INFORMANT Address<br>Records: Spring Grove State Hospital   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonitis, bilateral, org. unk.</u><br>3949<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Decubitus ulcers over the sacral region</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <u>Chronic Congestive Ht. Failure 2ny to</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>mitral stenosis and ASCVHD</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>410X |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 wk.<br>2 wks.<br>1 month |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>10/23</u> , 19 <u>67</u> , to <u>April 19</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 19</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Anthony J. Young</i>   |  | 22c. DATE SIGNED<br>4-19-68   |  | 22d. PHYSICIAN'S NAME (Type)<br>Anthony J. Young, M.D.  |  |  |  |  |  |
| 22e. ADDRESS<br>Spring Grove State Hospital<br>Baltimore, Maryland 21228  |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Entombment   |  | 23b. DATE<br>4/23/68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Cockeysville, Md. Balto.            |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br>Wm. Cook-Brooks Towson 1050 York Rd. 21204  |  |   |  | 25a. REC'D BY REGISTRAR<br>APR 23 1968 REGISTRAR'S SIGNATURE<br><i>James Judge</i>  |  |  |  |  |  |

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The members, especially, are, and

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I have been elected over and over again

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I have been elected over and over again

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05361

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05363

|   |                  |  |  |  |  |  |  |  |  |
|---|------------------|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or Print) <b>Steven Dennis Reidt</b>   |                  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>April</b> Day <b>28</b> Year <b>1968</b>  |  |  |  | 2b. HOUR <b>9:25</b> M   |  |
| 3. SEX <b>m</b>   | 4. RACE <b>w</b> | 5. DATE OF BIRTH <b>6-8-1949</b>   | 6. AGE (In years last birthday) <b>18</b> YRS. | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD Month <b>April</b> Day <b>28</b> Year <b>1968</b>       |  |
| 7a. BIRTHPLACE (State or foreign country) <b>md.</b>  |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Balto.</b>   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Freeland</b>   |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Walker Rd.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Student</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>High School</b>   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Penn.</b>  |                  | 13b. COUNTY <b>York</b>  |  | 13c. CITY OR TOWN <b>New Freedom</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>Singer Rd.</b>   |  |
| 14. FATHER'S NAME First <b>Donald L.</b> Middle <b>Reidt</b> Last <b>Reidt</b>  |                  |  |  | 15. MOTHER'S MAIDEN NAME First <b>Dorothy L.</b> Middle <b>Stansbury</b> Last <b>Stansbury</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                  | 16b. SOCIAL SECURITY NO. <b>220-5K-5165</b>  |  | 17. INFORMANT ADDRESS <b>Donald L. Reidt, New Freedom, Pa. 17349</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Crushing Injuries of Chest &amp; Head</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sudden</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Sudden</b>  |                  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>8:12</b>  |                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY Month, Day, Year <b>April 28 1968</b> P.M.                                 |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Head on Collision with another Motorcyclist</b>                       |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Highway</b>    |  | 21f. LOCATION (Street or R.F.D. No., City or Town, County, State) <b>Walker Rd - North of Parkton</b>  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>  |                  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  | 22b. DATE SIGNED <b>4/28/68</b>  |  |
| EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>  |                  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                      |  |
| ADDRESS (Street, city, town, or county)   |                  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                  | 23b. DATE <b>5-1-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>Freeland, Balto. md.</b>                    |  |  |  |
| 24. FUNERAL DIRECTOR <b>Harlenstein, New Freedom, Pa.</b>   |                  |  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR <b>MAY 2 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                                  |  |

52326

UNITED STATES DEPARTMENT OF AGRICULTURE

52326

UNITED STATES DEPARTMENT OF AGRICULTURE



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "UNITED STATES" and "DEPARTMENT OF AGRICULTURE" are visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| 05362   |  |  |   |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |  |  |  |                             |  |  |  |  | 05364    |  |  |  |  |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|--|---|--|--|--|--|-----------------------------|--|--|--|--|----------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last  |  |  |   |  |  |  |  |  |  | 2a. DATE OF DEATH Month Day Year  |  |  |  |  |                             |  |  |  |  | 2b. HOUR |  |  |  |  |  |  |  |  |  |
| FLORENCE A. REIGLE  |  |  |   |  |  |  |  |  |  | 4 21 68   |  |  |  |  |                             |  |  |  |  | 5 AM     |  |  |  |  |  |  |  |  |  |
| 3. SEX F.   |  |  | 4. RACE W.  |  |  | 5. DATE OF BIRTH FEB. 2, 1892  |  |  | 6. AGE (In years lost birthday) 76 YRS.  |   |  | IF UNDER 1 YEAR MONTHS DAYS              |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) BALTO MD  |  |  | 7b. CITIZEN OF WHAT COUNTRY? U. S. A.   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH BALTIMORE Md.   |   |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH BALTIMORE   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 138 CHERRYDELL |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sales lady   |  |  | 12b. KIND OF BUSINESS, OR INDUSTRY Retired   |   |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND  |  |  | 13b. COUNTY BALTIMORE   |  |  | 13c. CITY OR TOWN CATONSVILLE  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  | 13e. STREET AND NUMBER 138 CHERRYDELL RD |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last John H. ARMEHING  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last Lillian C. Kimpel                                |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No   |  |  | 16b. SOCIAL SECURITY NO. 215059258  |  |  | 17. INFORMANT Address GEORGE M. REIGLE 3203 S. 117 STREET OMAHA NEB. 68144   |  |  |  |   |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-vascular Disease   |  |  |   |  |  |  |  |  |  | yrs.  |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 4129 DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |   |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 4221  |  |  |   |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from Nov. 19 56, to April 19 68, that (I) (we) last saw the deceased alive on March 26 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE Leo J. Gaver   |  |  | DEGREE  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  |  | 22c. DATE SIGNED April 22, 1968  |   |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  | 22e. ADDRESS 1 Mallow Hill Ave., Baltimore, Md  |  |  |  |  |  |  |   |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  |  | 23b. DATE 4-24-68   |  |  | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY  |  |  | 23d. LOCATION (City or Town) (County) (State) NORTH AVE BALTO MD.                            |   |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  | ADDRESS   |  |  | 25a. REC'D BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE   |   |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| DIPPEL BROTHERS INC.  |  |  | 7110 BELAIR RD  |  |  | DATE APR 24 1968   |  |  | Charles J. [Signature]   |   |  |  |  |  |                             |  |  |  |  |          |  |  |  |  |  |  |  |  |  |

57320



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05363

05365

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Nicholas D. RETOS</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>21</b> Year <b>68</b> |   |  | 2b. HOUR<br><b>M</b>  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>9-1887</b>   |  | 6. AGE (In years lost birthday)<br><b>80</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Greece</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Greece</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Forest Haven Conv. Home</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Waiter</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>First <b>Demetre</b>  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Unknown</b>   |  | 13e. STREET AND NUMBER<br><b>7141 Holabird Ave.</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-14-2175</b>   |  | 17. INFORMANT<br><b>Mrs. Stella Pappas</b>  |  | Address<br><b>7937 St. Gregory, Baltimore Md. 21222</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>APUD E INMAGNO CEREBRO</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>UNUSUAL INSURMINATION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221</b>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/5</b> , 19 <b>62</b> , to <b>4/21</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>4/21</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>John H. [Signature]</b>   |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>4/24/68</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>John H. [Signature]</b>   |  |  |  | 22e. ADDRESS<br><b>5800 [Address]</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4-23-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greek Orthodox Cem.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>                           |  |
| 24. FUNERAL DIRECTOR<br><b>Nicholas T. Matthews, 3021 Eastern Ave Baltimore, Md.</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 24 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

2282

2282

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VR A15-14  
30M REV. 1/68

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |   |   |   |  |  |
|---|--|--|--|---|---|---|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |   |   |   |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |   |   |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>GERTRUDE</b>   |  |  | First <b>B</b> Middle <b>ROBINSON</b> Last   |   |   | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>8</b> Year <b>1968</b>                   |   | 2b. HOUR<br><b>10 A M</b>   |  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br><b>MAY 26, 1912</b>   |   | 6. AGE (In years last birthday)<br><b>55</b> YRS.                                       |   | IF UNDER 1 YEAR<br>MONTHS <b>5</b> DAYS <b>5</b> IF UNDER 24 HRS.<br>HOURS <b>5</b> MIN. <b>5</b> |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>7902 IVY LANE</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>   |  |  | 13b. COUNTY <b>BALTO</b>   |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>7902 IVY LANE</b> |  |
| 14. FATHER'S NAME<br>First <b>MEYER</b> Middle <b>BRADY</b> Last <b>BRADY</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>SARAH</b> Middle <b>BRADY</b> Last <b>BRADY</b>                 |   |   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-162484</b>  |   | 17. INFORMANT<br><b>HARRY ROBINSON</b>  |   | Address<br><b>7902 IVY LANE</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>174X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of breast, metastatic</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>16 yrs</b>                                     |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>170X</b>   |  |  |  |   |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. <b>19</b> Month <b>Dec</b> Day <b>65</b> Year <b>1968</b><br>P.M. <b>19</b> |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                               |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |  |   | 21f. LOCATION<br>Street or R.F.D. No. <b>Dec</b> City or Town <b>April</b> County <b>1968</b> State <b>MD</b> |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec</b> , 19 <b>65</b> , to <b>April</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>April 5, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |  |  |   |   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Daniel Bakal MD</b>  |  |  |  |   | 22c. DATE SIGNED<br><b>4-8-68</b>   |   |   |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DANIEL BAKAL, M.D.</b>   |  |  |  |   | 22e. ADDRESS<br><b>3600 Lochearn Dr, Baltu</b>  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4/10/1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH TILSON</b>  |   | 23d. LOCATION (City or Town)<br><b>BALTO</b> (County) <b>MD</b> (State)                 |   |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Sylvan S. Lewis &amp; Son, Inc</b>   |  |  |  |   | ADDRESS<br><b>Garrison, Md</b>  |   | 25a. REC'D BY REGISTRAR<br><b>APR 10 1968</b>   |   |  |  |
|   |  |  |  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Judge</b>  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)  
30M REV. 1/68

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |                                   |  |  |
|--|--|--|--|--|--|---|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |                                   |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |                                   |  |  |
| 1. DECEASED-NAME (Type or print)   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |  | 2b. HOUR                          |  |  |
| CHRISTIAN INM. Rodey   |  |  |  |  |  | Month Day Year  |  | 210 M                             |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | 7. YRS.                           |  |  |
| M  |  | W  |  | 9/29/1896  |  | 71  |  |                                   |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  | Md.                               |  |  |
| Md   |  | U.S.A  |  |  |  | BALTO.  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| CATONSVILLE  |  |  | 2018 Rollingwood Rd  |  |  | ENGINEER  |  | RAILROAD                          |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER                                 |  |
| Md   |  |  | BALTO  |  | CATONSVILLE  |   |  |                                   | 2018 Rollingwood Rd                                    |  |
| 14. FATHER'S NAME First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |   |  |                                   |  |  |
| CHRISTIAN Rodey  |  |  | BERTHA WHITUM  |  |  |   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |   | Address  |                                   |  |  |
| No   |  |  |  |  |  |   |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute anemia</u><br>792X<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day. |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>792X   |  |  |  |  |  |   |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |  |  |
|  |  |  |  |  |  |   |  |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |                                   |  |  |
|  |  |  |  |  |  |   |  |                                   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town  |  | County State                      |  |  |
|  |  |  |  |  |  |   |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/9, 1968, to 4/9, 1968, that (I) (we) last saw the deceased alive on 4/9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |                                   |  |  |
| 22b. SIGNATURE Robert A. Reiter, M.D.  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED 4/10/68   |                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type) Robert A. Reiter, M.D.  |  |  |  |  | 22e. ADDRESS 606 Edmondson Ave. 21328  |   |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |  |  |
| BURIAL   |  | 4/12/68  |  | LORAIN CEM.  |  | BALTO. Md.  |  |                                   |  |  |
| 24. FUNERAL DIRECTOR ES. M. Malt   |  |  |  | ADDRESS CATONSVILLE MD.  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE        |  |  |
|  |  |  |  |  |  | DATE APR 15 1968  |  | Charles Judge                     |  |  |

18826

18826





# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div>05368</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 3</div> <div>05368</div>   |  |         |  |                              |  |  |  |  |        |   |  |   |  |  |  |                                   |  |
|--|--|---------|--|------------------------------|--|--|--|--|--------|---|--|---|--|--|--|-----------------------------------|--|
| 1. DECEASED-NAME (Type or Print)   |  |         |  |                              |  | First  |  |  | Middle |   |  | Last  |  |  |  |                                   |  |
| Mary   |  |         |  |                              |  | Roemer   |  |  |        |   |  |   |  |  |  |                                   |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH             |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR  |        | IF UNDER 24 HRS   |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR                                     |  |                                   |  |
| Female   |  | W       |  | 7-5-1873                     |  | 94 YRS.  |  | MONTHS   |        | DAYS  |  | 2c. DATE PRONOUNCED DEAD  |  | 2d. HOUR                                     |  |                                   |  |
|  |  |         |  |                              |  |  |  |  |        |   |  | April 27 1968   |  | 8 M  |  |                                   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY? |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        |   |  | 9. COUNTY OF DEATH  |  |  |  |                                   |  |
| Maryland   |  |         |  | U.S.A.                       |  |  |  |  |        |   |  | Baltimore Md.   |  |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  |                              |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |        |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Baltimore, Md  |  |         |  |                              |  | St Joseph Hospital   |  |  |        |   |  |   |  |  |  |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |         |  |                              |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |        | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER  |  |  |  |                                   |  |
| Md.  |  |         |  |                              |  | Baltimore  |  | Towson   |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 615 Chesnut Ave.  |  |  |  |                                   |  |
| 14. FATHER'S NAME  |  |         |  |                              |  | 15. MOTHER'S MAIDEN NAME   |  |  |        |   |  |   |  |  |  |                                   |  |
| First Middle Last  |  |         |  |                              |  | First Middle Last  |  |  |        |   |  |   |  |  |  |                                   |  |
| Martin Roemer  |  |         |  |                              |  | Margarette Frey  |  |  |        |   |  |   |  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |         |  |                              |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |        |   |  |   |  | ADDRESS                                      |  |                                   |  |
| No   |  |         |  |                              |  | 214-01-1578  |  | Pickersgill Home   |        |   |  |   |  | 615 Chesnut Ave. 21204                       |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |         |  |                              |  |  |  |  |        |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                   |  |
| PART I. DEATH WAS CAUSED BY:   |  |         |  |                              |  |  |  |  |        |   |  |   |  |  |  |                                   |  |
| IMMEDIATE CAUSE (a) <u>Fractured Skull</u>   |  |         |  |                              |  |  |  |  |        |   |  |   |  | 24 Hrs                                       |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |                              |  |  |  |  |        |   |  |   |  |  |  |                                   |  |
| (b)  |  |         |  |                              |  |  |  |  |        |   |  |   |  |  |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |                              |  |  |  |  |        |   |  |   |  |  |  |                                   |  |
| (c)  |  |         |  |                              |  |  |  |  |        |   |  |   |  |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |         |  |                              |  |  |  |  |        |   |  |   |  |  |  |                                   |  |
| 19a. DATE OF OPERATION   |  |         |  |                              |  |  |  |  |        |   |  |   |  |  |  |                                   |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |         |  |                              |  |  |  |  |        |   |  |   |  |  |  |                                   |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |         |  |                              |  |  |  |  |        |   |  |   |  |  |  |                                   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  |                              |  | 21b. TIME OF INJURY Month, Day, Year   |  |  |        |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |  |  |                                   |  |
|  |  |         |  |                              |  | April 27 1968  |  |  |        |   |  | Fell out of Bed   |  |  |  |                                   |  |
| 21d. INJURY OCCURRED   |  |         |  |                              |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |  |        |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |  |  |  |                                   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |         |  |                              |  | Home   |  |  |        |   |  | 615 W. Chesnut Ave. Towson Md.  |  |  |  |                                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |  |                              |  |  |  |  |        |   |  |   |  |  |  |                                   |  |
| ACTUAL SIGNATURE   |  |         |  |                              |  | CHIEF MEDICAL EXAMINER   |  |  |        |   |  | 22b. DATE SIGNED  |  |  |  |                                   |  |
| EXAMINER'S NAME (Type)   |  |         |  |                              |  | ASSISTANT MEDICAL EXAMINER   |  |  |        |   |  | 4/27/68   |  |  |  |                                   |  |
| Charles F. O'Donnell, M.D.   |  |         |  |                              |  | DEPUTY MEDICAL EXAMINER  |  |  |        |   |  |   |  |  |  |                                   |  |
|  |  |         |  |                              |  | ADDRESS (Street, city, town, or county)                                      |  |  |        |   |  |   |  |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |         |  | 23b. DATE                    |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |        | 23d. LOCATION (City or Town) (County) (State)                       |  |   |  |  |  |                                   |  |
| Burial   |  |         |  | 4/30/68                      |  | Western Cemetery   |  |  |        | Baltimore, Md.  |  |   |  |  |  |                                   |  |
| 24. FUNERAL DIRECTOR   |  |         |  |                              |  | 25a. REC'D BY REGISTRAR  |  |  |        |   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |                                   |  |
| Wm. Cook-Brooks Towson 1050 York Rd. 21204   |  |         |  |                              |  | MAY 3 1968   |  |  |        |   |  | Charles Judge   |  |  |  |                                   |  |

03510

HEALTH DEPT. 2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form I-5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

|  |                         |  |  |   |   |   |   |  |                             |
|--|-------------------------|--|--|---|---|---|---|--|-----------------------------|
| 1. DECEASED-NAME<br>(Type or Print)<br><b>Robina Meeteer Roeth</b>   |                         |  | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> Month <b>4</b> Day <b>11</b> Year <b>1968</b> |   |   | 2b. HOUR<br><b>6:00</b> P M   |   |  |                             |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>12-25-1884</b>  | 6. AGE (in years last birthday)<br><b>83</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS   | IF UNDER 24 HRS<br>HOURS<br>MIN   | 2c. DATE PRONOUNCED DEAD<br>Month <b>April</b> Day <b>11</b> Year <b>1968</b>                   |   |  | 2d. HOUR<br><b>7:45</b> P M |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Chestertown, USA</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |  |                             |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>5415 Montbel Avenue</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>At Home</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                    |                             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |                         | 13b. CITY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>5415 Montbel Avenue</b> |                             |
| 14. FATHER'S NAME First Middle Last<br><b>Charles Rolph</b>  |                         |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Robina Watkin</b>   |   |   |   |   |  |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>NO</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>None</b>                           |  | 17. INFORMANT ADDRESS<br><b>Joseph H. Radcliffe-5415 Montbel Avenue</b>   |   |   |   |  |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Terminal Carcinoma Liver</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |                         |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>1561 Arteriosclerotic Cardio-Vascular Disease</b>  |                         |  |  |   |   |   |   |  |                             |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |  |                             |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. 19<br>P.M.   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |  |                             |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                               |  | 21f. LOCATION Street or R.F.D. No.  |   |   | City or Town  |  | County State                |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |  |   |   |   |   |  |                             |
| ACTUAL SIGNATURE <b>James N. Frederick M.D.</b>  |                         |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   | 22b. DATE SIGNED <b>4/11/68</b>   |  |                             |
| EXAMINER'S NAME (Type) <b>James N. Frederick M.D.</b>  |                         |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   | 1311 Hanas Ave  |  |                             |
|  |                         |  |  | ADDRESS (Street, city, town, or county) <b>Balt 27 and</b>  |   |   |   |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 23b. DATE<br><b>4-13-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b> |  |                             |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Ellsworth Armacost-4600 Liberty Hghts. Ave.</b>   |                         |  |  | 25a. REC'D BY REGISTRAR<br><b>APR 15 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |  |                             |

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

|   |                         |   |  |
|---|-------------------------|---|--|
| 05368   |                         | 05370   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>LOUIS G ROHNACHER</b>  |                         | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>6</b> Year <b>1968</b>   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>FEB- 3-1919</b>  |  |
| 6. AGE (In years last birthday)<br><b>49</b> YRS.   |                         | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Balto</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |                         | 9. COUNTY OF DEATH<br><b>BALTIMORE - COUNTY</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE - COUNTY</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>BALTIMORE - COUNTY GENERAL</b> |  |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Funeral Director</b>  |                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Funeral</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |                         | 13b. COUNTY <b>BALTO</b>  |  |
| 13c. CITY OR TOWN<br><b>BALTO</b>   |                         | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  |
| 13e. STREET AND NUMBER<br><b>3521 Rd. Balto 21007</b>   |                         | 13f. CITY AND ZIP CODE<br><b>BALTO 21007</b>  |  |
| 14. FATHER'S NAME First <b>John</b> Middle <b>Rehnacher</b> Last <b>Rehnacher</b>   |                         | 15. MOTHER'S MAIDEN NAME First <b>Louise</b> Middle <b>Dietz</b> Last <b>Dietz</b>                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>Yes</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>217-05-9429</b>  |  |
| 17. INFORMANT<br><b>Mrs. Margaret D. Rehnacher</b>  |                         | Address <b>Balto 21007</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Ca. of the STOMACH</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1519</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                         |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>151X</b>   |                         |   |  |
| 19a. DATE OF OPERATION<br><b>151X</b>   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>151X</b>   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                         | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |                         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                         | 21d. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |
| 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |                         | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-13-1968</b> , to <b>4-6-1968</b> , that (I) (we) lost the deceased on <b>4-6-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |                         |   |  |
| 22b. SIGNATURE<br><b>Francisco Saez</b>   |                         | 22c. DATE SIGNED<br><b>4-6-68</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>FRANCISCO SAEZ</b>   |                         | 22e. ADDRESS<br><b>Baltimore County, Baltimore, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>4/6/68</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>   |                         | 23d. LOCATION (City or town) (County) (State)<br><b>Woodlawn Md</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Lonnie Byars, 8778 Liberty Road</b>  |                         | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 11 1968</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                         |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED

1922

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |   |   |  |  |   |  |
|---|--|--|---|--|---|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |   |   |  |  |   |  |
| CERTIFICATE OF DEATH  |  |  |   |  |   |   |  |  |   |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>ESTHER ROSE</b>  |  |  |   |  | 2a. DATE OF DEATH Month Day Year<br><b>APRIL 29, 1968</b>                       |   |  | 2b. HOUR<br><b>3:45 PM</b>   |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br><b>APRIL 16, 1900</b>  |   |   | 6. AGE (In years lost birthday)<br><b>68</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>BOSTON, MASS.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. JOSEPHS HOSPITAL</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>     |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>PARKVILLE</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>8410 NUNLEY DRIVE</b>      |  |
| 14. FATHER'S NAME First Middle Last<br><b>RUBEN SKLAR</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>PAULINE ?</b>   |   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |  |  |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address<br><b>MRS. EDITH MAGILNER, 2088 B N. JOHN RUSSEL CIR. LYNNWOOD GARDEN PARK ELKINS</b> |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |   |  |   |   |  |  |   |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> 410.9 DUE TO, OR AS A CONSEQUENCE OF (b) <b>art sel cv disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>8 yrs</b>  |  |  |   |  |   |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201 none</b>  |  |  |   |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>none</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/12, 1968</b> to <b>4/29, 1968</b> , that (I) (we) last saw the deceased alive on <b>4/29, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Maurice Feldman MD</b>   |  |  |   |  | 22c. DATE SIGNED<br><b>4/29/68</b>  |   | 22d. PHYSICIAN'S NAME (Type)<br><b>MAURICE FELDMAN</b>                                       |  |   |  |
| 22e. ADDRESS<br><b>6610 CROSS COUNTRY BLVD.</b>   |  |  |   |  |   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL-REMOVAL</b>  |  | 23b. DATE<br><b>4-29-68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOMBARDY</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>WILMINGTON, DELAWARE</b>                 |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>   |  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>DATE APR 30 1968</b>                              |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |  |

25371

25371

APRIL 14, 1900

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FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |   |                                   |   |  |
|---|--|--|--|---|--|--|--|---|-----------------------------------|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |                                   |   |  |
| 1. DECEASED-NAME (Type or Print)<br>First Middle Last<br><b>JAMES JOSEPH ROSSO</b>  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED<br><input checked="" type="checkbox"/> Month Day Year<br><b>April 17, 1968</b> |  |   | 2b. HOUR<br><b>2P</b>             |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>7/17/1910</b>  |  | 6. AGE (In years last birthday)<br><b>57</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |                                   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>April 17, 1968</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |   |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph's Hospital</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Musician</b>       |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Balto.</b>   |   |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER<br><b>Daybreak 5612 Daybreak Terr.</b>       |  |
| 14. FATHER'S NAME First Middle Last<br><b>Salvatore Rosso</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Josephine 7 Piraino</b>  |  |  |  |   |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215 16 7316</b>                               |  | 17. INFORMANT ADDRESS<br><b>Mrs. Marie M. Rosso- 5612 Daybreak Terr</b>   |  |  |  |   |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Generalized Arteriosclerotic Cardio</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Renal Vascular disease while Under General</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4427</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Anesthetic Pulmonary Emphysema</b> |  |  |  |   |  |  |  |   |                                   |   |  |
| 19a. DATE OF OPERATION<br><b>4/17/68</b>  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>Amputation of Rt Forefoot and bilateral Sympathectomy</b>   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |                                   |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>19</b>             |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Private</b>   |  |  |  |   |                                   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town<br><b>Permissive</b> County State   |  |  |  |   |                                   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |  |  |   |  |  |  |   |                                   |   |  |
| ACTUAL SIGNATURE<br><b>Charles F. O'Donnell</b> M.D.  |  |  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>         |  |
| EXAMINER'S NAME (Type)<br><b>Charles F. O'Donnell, M.D.</b>   |  |  |  |   |  | ADDRESS (Street, city, town, or county)  |  | 22b. DATE SIGNED<br><b>4/17/68</b>  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/22/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.,</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>   |  |   |                                   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. 5305 Harford Rd. #14</b>  |  |  |  | ADDRESS   |  | 25a. RECD BY REGISTRAR<br><b>APR 18 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |                                   |   |  |

00330

00330

THE  
UNITED STATES  
DEPARTMENT OF  
THE ARMY  
OFFICE OF THE  
CHIEF OF MEDICAL  
SERVICES  
WASHINGTON, D. C.



TO: THE CHIEF OF MEDICAL SERVICES, DEPARTMENT OF THE ARMY, WASHINGTON, D. C.

FROM: THE CHIEF OF MEDICAL SERVICES, DEPARTMENT OF THE ARMY, WASHINGTON, D. C.

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05371

05373

|   |  |  |  |   |                                |   |  |  |  |                                |  |                               |  |
|---|--|--|--|---|--------------------------------|---|--|--|--|--------------------------------|--|-------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Rebecca Aiken Rothman</i>  |  |  | First Middle Last  |   |                                | 2a. DATE OF DEATH<br>Month Day Year <i>April 14 1968</i>  |  |  | 2b. HOUR <i>12 P.M.</i>  |                                |  |                               |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>                    |  | 5. DATE OF BIRTH<br><i>May 28, 1899</i>   |                                |   | 6. AGE (In years lost birthday) <i>68</i> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS |  | IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Poland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.  |  |  |  |                                |  |                               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Pikesville</i>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Meadow Manor Home</i> |   |                                | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Housewife</i>                     |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>at home</i>                  |                                |  |                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Baltimore</i>   |  |  | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>md</i> |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>Liberty Road</i>                        |                                |  |                               |  |
| 14. FATHER'S NAME<br>First Middle Last<br><i>Joseph Pinkner</i>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><i>Yetta</i>  |   |                                |   |  |  |  |                                |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><i>no</i> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |   |                                | 17. INFORMANT<br>Signature <i>Aiken</i> - 4100 Bedford Rd<br>Address  |  |  |  |                                |  |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma of Pancreas</i><br><i>1579</i> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>8 months</i> |  |  |  |   |                                |   |  |  |  |                                |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>157X</i>   |  |  |  |   |                                |   |  |  |  |                                |  |                               |  |
| 19a. DATE OF OPERATION<br><i>Feb 1968</i>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Cancer of Pancreas</i>                            |   |                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                |  |                               |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |   |                                | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |                                |  |                               |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |   |                                | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |                                |  |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1967</i> , 19 <i>68</i> , to <i>4/15</i> , 19 <i>68</i> , that (I) ( <del>was</del> ) last saw the deceased alive on <i>4/15</i> , 19 <i>68</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.      |  |  |  |   |                                |   |  |  |  |                                |  |                               |  |
| 22b. SIGNATURE<br><i>Milton Kirsh</i>   |  |  | DEGREE <i>MD</i>   |   |                                | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><i>4-15-68</i>                                   |                                |  |                               |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>MILTON KIRSH</i>   |  |  | 22e. ADDRESS<br><i>4000 Northern Parkway</i>   |   |                                |   |  |  |  |                                |  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  |  | 23b. DATE<br><i>April 15/68</i>  |   |                                | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Hebrew Young Men</i>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Woodlawn, Md</i> |                                |  |                               |  |
| 24. FUNERAL DIRECTOR<br><i>Sol Lenson &amp; Bros</i>  |  |  | ADDRESS<br><i>6010 Reest Rd</i>  |   |                                | 25a. REC'D BY REGISTRAR<br>DATE <i>APR 17 1968</i>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                   |                                |  |                               |  |

MEDICAL CERTIFICATION

1930-1931

1931

1932

1933

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1935

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

05372

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05374

|   |                         |  |   |  |   |
|---|-------------------------|--|---|--|---|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>IRVIN NORMAN RUBIN</b>  |                         |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>APRIL 5, 1968</b>   |  | 2b. HOUR<br><b>2:30A.M.</b>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br><b>JUNE 7, 1924</b>  |   | 6. AGE (In years lost birthday)<br><b>43</b> YRS.  |   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>HARRISBURG, PA.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.                                  |
| 10. CITY OR TOWN OF DEATH<br><b>OWINGS MILLS</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>APT. 303 107 ENCHANTED HILL RD.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>SALESMAN</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>INSURANCE</b>                       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |                         | 13b. COUNTY<br><b>BALTIMORE</b>  | 13c. CITY OR TOWN<br><b>OWINGS MILLS</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 13e. STREET AND NUMBER<br><b>APT. 303 107 ENCHANTED HILLS ROAD</b>          |
| 14. FATHER'S NAME First Middle Last<br><b>HYMAN RUBIN</b>   |                         |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>LENA ?</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service)<br><b>W.W. II ARMY</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>204-03-8870</b>   | 17. INFORMANT Address<br><b>MRS. FRANCES RUBIN, 107 ENCHANTED HILLS RD. APT. 303</b>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Atherosclerosis of coronary arteries</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 minutes</b> |                         |  |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>   |                         |  |   |  |   |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |                         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                            |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/4/68</b> , 19 <b>68</b> , to <b>4/4/68</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>4/4/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |                         |  |   |  |   |
| 22b. SIGNATURE<br><b>Philip Bernstein</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |                         |  |   | 22c. DATE SIGNED<br><b>4/4/68</b>  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>PHILIP BERNSTEIN</b>   |                         | 22e. ADDRESS<br><b>112 CHARTLEY DRIVE</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>4-7-68</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>(ARLINGTON) CHIZUK AMUNO</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN RD. #15</b>  |                         | ADDRESS  |   | 25a. RECEIVED BY REGISTRAR<br><b>APR 10 1968</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Judge</b>                                  |

5793

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4157  
30M REV 11-66

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05373

05375

|  |  |  |  |   |   |   |  |   |  |  |                           |  |
|--|--|--|--|---|---|---|--|---|--|--|---------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Doris</b>  |  | First<br><b>G.</b>   |  | Middle<br><b>RUDY</b>   |   | Last  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>April 1, 1968</b>   |  |  | 2b. HOUR<br><b>6:10AM</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>August 31, 1904</b>  |   |   | 6. AGE (In years lost birthday)<br><b>63</b> YRS.                      |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |                           |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. COUNTY OF DEATH<br><b>Baltimore,</b> Md.                            |   |  |  |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. JOSEPH HOSPITAL</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Homemaker</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  |  |                           |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>3713 Delverne Rd.</b>  |  |  |                           |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>James N. Pfeiffer</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Elizabeth Humerick</b>  |   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b> |  |  |                           |  |
| 16b. SOCIAL SECURITY NO.<br><b>217-09-2244</b>   |  |  |  | 17. INFORMANT<br>Address<br><b>Daniel W. Rudy, 5536 Rockburn Hill Rd., Elkridge 21227</b>   |   |   |  |   |  |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>571.8</b> IMMEDIATE CAUSE (a) <b>Massive gastro-intestinal hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>bleeding esophageal varices</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>portal cirrhosis</b>   |  |  |  |   |   |   |  |   |  |  |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>5810</b>  |  |  |  |   |   |   |  |   |  |  |                           |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |   |  |  |                           |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                             |   |  |   |  |  |                           |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |   |  |   |  |  |                           |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 25, 1968</b> , to <b>April 1, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 1, 1968</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |   |  |  |                           |  |
| 22b. SIGNATURE<br><b>Lawrence F. Misanik</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |  |  |   |   |   |  | 22c. DATE SIGNED<br><b>April 1, 1968</b>  |  |  |                           |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Lawrence F. Misanik, M.D.</b>   |  |  |  |   |   |   |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>   |  |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/4/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |   |  |  |                           |  |
| 24. FUNERAL DIRECTOR<br><b>H. W. Jenkins &amp; Sons Co.</b> ADDRESS<br><b>4905 York Rd. Balt 12, Md.</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 3 - 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |  |  |                           |  |

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James M. ...  
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James M. ...  
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James M. ...  
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James M. ...  
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05374

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05376

1. NAME OF DECEASED  
(Type or Print)

August Russo

2. DATE AND HOUR OF DEATH

4-29-68

2:30 P M

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

Baltimore County

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Chesapeake Manor Nursing Home  
509 E. Joppa Road. Balto. Md.  
21204

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3108 Weaver Avenue, 21214

5. SEX

Male

6. RACE

White

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

Oct 16 1875

9. AGE (In years  
last birthday)

92

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Bartender

10B. KIND OF BUSINESS OR INDUSTRY

Tavern

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Carmello Russo

14. MOTHER'S MAIDEN NAME

Salvatora Russo

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

218 32 3875

17. INFORMANT

ADDRESS

A Marie S. Young, 3108 Weaver Ave. 21214

18.

4129 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerotic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

22. I certify that (I) (this hospital) attended the deceased from 1-1-68 to 4-29-68  
that (I) (we) lost saw the deceased alive on 4-29-68 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Sebastian Russo

DEGREE

Attending  
Phys.Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

5/1/68

23C. PHYSICIAN'S  
NAME (Type)

Dr. Sebastian Russo

DEGREE

23D. ADDRESS

5017 Harford Road. Balto. Md. 21214

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5-2-68

24C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

VR A15 25A. DATE REC'D BY HEALTH DEPT.  
30M REV. MAY 6 1968

25B. NAME OF REGISTRAR

Charles J. J...

25C. FUNERAL DIRECTOR

ADDRESS

Wm. E. Johnson 8521 Loch Raven Blvd. 21204

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)





FOR STATE HEALTH DEPT.

05375

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05377

|  |                  |   |   |  |  |   |  |  |                         |
|--|------------------|---|---|--|--|---|--|--|-------------------------|
| 1. DECEASED-NAME (Type or Print) <b>Margaret V. Ryan</b>   |                  |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>4</b> Day <b>26</b> Year <b>1968</b>   |  |  | 2b. HOUR <b>6:00 PM</b>   |  |  |                         |
| 3. SEX <b>F</b>  | 4. RACE <b>W</b> | 5. DATE OF BIRTH <b>2-23-1912</b>   | 6. AGE (In years last birthday) <b>56</b> YRS.  | IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>  |  | IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>   |  | 2c. DATE PRONOUNCED DEAD Month <b>4</b> Day <b>26</b> Year <b>1968</b> | 2d. HOUR <b>6:40 PM</b> |
| 7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>  |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore</b> Md.   |  |  |                         |
| 10. CITY OR TOWN OF DEATH <b>Catonsville</b>   |                  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Spring Grove</b>  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                       |  | 12b. KIND OF BUSINESS OR INDUSTRY                                      |                         |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>  |                  |   | 13b. COUNTY <b>Charles</b>  |  | 13c. CITY OR TOWN <b>Indian Head</b>   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  | 13e. STREET AND NUMBER <b>Indian Head, Md.</b>                                   |  |                         |
| 14. FATHER'S NAME First <b>John</b> Middle <b>C</b> Last <b>Ryan</b>   |                  |   | 15. MOTHER'S MAIDEN NAME First <b>Cecelia</b> Middle <b>Boswell</b> Last <b>Boswell</b>   |  |  |   |  |  |                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |                  |   | 16b. SOCIAL SECURITY NO. <b>NONE</b>  |  | 17. INFORMANT <b>Dr. F. Guzman</b> ADDRESS <b>Spring Grove Hosp.</b>   |   |  |  |                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxiation by Aspiration</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |                  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>             |                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>9217</b>  |                  |   |   |  |  |   |  |  |                         |
| 19a. DATE OF OPERATION   |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                         |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |   | 21b. TIME OF INJURY Month, Day, Year <b>4/26 4/26 1968</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Aspirated Fish Cake at Dinner</b> |   |  |  |                         |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK  |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Spring Grove Hosp</b> |   | 21f. LOCATION Street or R.F.D. No. <b>Catonsville</b> City or Town <b>Balto.</b> County <b>Md</b> State  |  |   |  |  |                         |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |   |   |  |  |   |  |  |                         |
| ACTUAL SIGNATURE <b>James N. Frederick</b> EXAMINER'S NAME (Type) <b>James N. Frederick</b>  |                  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |  | 22b. DATE SIGNED <b>4/26/68</b> ADDRESS (Street, city, town, or county) <b>1311 Francis Ave Balt. Md 2122</b> |  |  |                         |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                  | 23b. DATE <b>May 3, 1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>FISGAH</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>FISGAH Chas Md</b>   |  |  |                         |
| 24. FUNERAL DIRECTOR <b>The Hunt-Turner-Hone, Waldorf Md</b> ADDRESS   |                  |   |   | 25a. REC'D BY REGISTRAR <b>MAY 6 1968</b> DATE   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  |  |                         |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 05376   |  | 05378   |  |   |  |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>EDITH</b>  |  | First <b>SANTMYER</b>   |  | Last  |  | 2a. DATE OF DEATH<br><b>April</b> Month <b>14</b> Day <b>1968</b>  |  | 2b. HOUR<br>M   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>7-12-1915</b>  |  | 6. AGE (In years<br>last birthday)<br><b>52</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN                 |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  | Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>931 Southridge Road</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>931 Southridge Road</b>                            |  |
| 14. FATHER'S NAME<br>First <b>Paul</b> Middle <b>J.</b> Last <b>Belschner</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Rose</b> Middle <b>Werntz</b> Last                                       |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Mr. James E. Santmyer, 931 Southridge Rd.</b>               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic carcinoma of left breast</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>10 years</b>  |  | 170X  |  | 19a. DATE OF OPERATION<br><b>30 Nov 59</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>breast mass</b>          |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                                       |  | 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)    |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (At home, farm, street, factory,<br>office building, etc.)                               |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>25 November, 1959</b> , to <b>14 April, 1968</b> , that (I) (we) last<br>saw the deceased alive on <b>8 April, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above. (I) (we) ( <del>did</del> ) (did not) view the body after death. |  | 22b. SIGNATURE<br><b>Dr. Irwin H. Moss, MD</b>                                  |  |
| 22c. DATE SIGNED<br><b>15 April 68</b>  |  | 22d. PHYSICIAN'S<br>NAME (Type) <b>Dr. Irwin H. Moss</b>  |  | 22e. ADDRESS<br><b>Westview Shopping Center, Catonsville, Md</b>  |  | 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4-17-1968</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cem.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                                   |  | 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 16 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Jones</b>                           |  |

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## CERTIFICATE OF DEATH

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05379

|  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>ANNA</b>  |  |  | First Middle Last <b>SCHAPIRO</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>19</b> Year <b>68</b>  |  |  | 2b. HOUR<br><b>3 PM</b>   |  |  |   |  |  |
| 3. SEX<br><b>FEMALE</b>  |  |  | 4. RACE<br><b>WHITE</b>  |  |  | 5. DATE OF BIRTH  |  |  | 6. AGE (In years<br>lost birthday)<br><b>80</b> YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>NEW YORK</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> Md.   |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>BALTIMORE COUNTY GEN. HOSP.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>HOUSEWIFE</b>  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>AT HOME</b>  |  |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>MD</b>   |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>22 WARREN PARK RD</b>  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>? XXXXXX KUSHINCK</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>? HINDA ?</b>  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT<br>Address <b>APT. C-1 #15</b><br><b>MR. RAYMOND SCHAPIRO, 3505 CLARKS LANE</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>3 days</b> |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221 DIABETES MELLITUS</b>  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                    |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 6, 1968</b> , to <b>April 19, 1968</b> , that (I) (we) last<br>saw the deceased alive on <b>April 19, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Josefina T. Naraval MD</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |  |  |  |  |   |  |  |   |  | 22c. DATE SIGNED<br><b>April 19, 1968</b>                        |   |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>JOSEFINA T. NARAVAL</b>   |  |  |  |  |  |   |  |  |   |  | 22e. ADDRESS<br><b>BALTO. COUNTY GEN HOSP</b>                    |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>4-21-69</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ANSHE EMUNAH (AITZ CHAIM)</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                     |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS. INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN ROAD, BALTO. 21215</b>   |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 23 1968</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1933

UNITED STATES OF AMERICA

1933





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |  |  |  |  |   |   |  |
|--|--|--|---|--|--|--|--|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |  |  |  |   |   |  |
| CERTIFICATE OF DEATH   |  |  |   |  |  |  |  |  |   |   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br>INFANT   |  |  | Middle<br>FEMALE   |  |  | Last<br>SCHEK   |   |  |
| 2a. DATE OF DEATH  |  |  | 4   |  |  | Month 7  |  |  | Day 68 Year   |   |  |
| 2b. HOUR   |  |  | 2:30P   |  |  | M  |  |  |   |   |  |
| 3. SEX   |  |  | Female  |  |  | 4. RACE  |  |  | White   |   |  |
| 5. DATE OF BIRTH   |  |  |   |  |  | 6. AGE (In years<br>lost birthday)   |  |  | YRS.  |   |  |
| IF UNDER 1 YEAR  |  |  | MONTHS  |  |  | DAYS   |  |  | IF UNDER 24 HRS.  |   |  |
| HOURS  |  |  | 14  |  |  | MIN.   |  |  |   |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore, Md.  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson, Maryland  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Greater Balto. Med. Center |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| Md.  |  |  | Balto.  |  |  | Lutherville  |  |  | 13e. STREET AND NUMBER<br>20 Dunwick Rd.  |   |  |
| 14. FATHER'S NAME  |  |  | First   |  |  | Middle   |  |  | Last  |   |  |
| 15. MOTHER'S MAIDEN NAME   |  |  | First   |  |  | Middle   |  |  | Last  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)   |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT  |  |  | Address   |   |  |
|  |  |  |   |  |  |  |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |   |  |  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hyaline Membrane Disease   |  |  |   |  |  |  |  |  |   |   |  |
| 7761 DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |  |  |  |   |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   |  |  |  |  |  |   |   |  |
| (b) Prematurity - 26 weeks   |  |  |   |  |  |  |  |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |  |  |  |  |   |   |  |
| (c)  |  |  |   |  |  |  |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |  |  |  |  |  |   |   |  |
| 7735   |  |  |   |  |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? Yes                     |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               |  |  | 21f. LOCATION Street or R.F.D. No.   |  |  | City or Town County State   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 7, 1968, to April 7, 1968, that (I) (we) lost saw the deceased alive on April 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |  |   |   |  |
| 22b. SIGNATURE   |  |  | RUDIGER BREITENECKER, M.D.  |  |  | DEGREE   |  |  | 22c. DATE SIGNED<br>April 8, 1968   |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  |  | Greater Baltimore Medical Center  |  |  | 22e. ADDRESS   |  |  |   |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  |  | 23b. DATE<br>4/8/68   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greater Balto. Med. Cen.   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Towson, Maryland                               |   |  |
| 24. FUNERAL DIRECTOR   |  |  | ADDRESS   |  |  | 25a. REC'D BY REGISTRAR<br>DATE  |  |  | 25b. REGISTRAR'S SIGNATURE  |   |  |
| 81-08957   |  |  | R. Breitenecker   |  |  | GBMC   |  |  | APR 11 1968 Charles Judge   |   |  |

*Handwritten signature*

*Handwritten text*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 4 and 5, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |                          |  |  |  |
|--|--|--|--|--|--|--|--|--------------------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |                          |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |                          |  |  |  |
| Item# 14, Film# G401 5/31/68 km  |  | 05381  |  |  |  |  |  |                          |  |  |  |
| 1. DECEASED-NAME (Type or print)   |  | First  |  | Middle   |  | Last   |  | 2a. DATE OF DEATH        |  | 2b. HOUR                                     |  |
| Mildred  |  | Edna   |  | Scherer  |  |  |  | Month 4 Day 17 Year 68   |  | 4 a M  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR          |  | IF UNDER 24 HRS                              |  |
| Female   |  | Cau  |  | 11/16/11   |  | 56 YRS.  |  | MONTHS DAYS              |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                          |  |  |  |
| Maryland   |  | USA  |  |  |  | Baltimore Md.  |  |                          |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                          |  |  |  |
| Towson   |  | Greater Balto Med. Center  |  | Housewife  |  | USA  |  |                          |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |  |  |
| Md.  |  |  |  | Baltimore  |  |  |  | 2003 Northbourne Rd.     |  |  |  |
| 14. FATHER'S NAME  |  | First  |  | Middle   |  | Last   |  | 15. MOTHER'S MAIDEN NAME |  | First Middle Last                            |  |
| Richard  |  | E. P. Waite  |  |  |  |  |  | Emma                     |  | E. Aring                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address  |  | (Same)                   |  |  |  |
|  |  |  |  | Mr. John W. Scherer  |  |  |  |                          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |                          |  |  |  |
| IMMEDIATE CAUSE (a) Carcinomatosis   |  |  |  |  |  |  |  |                          |  |  |  |
| 180X DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |                          |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Recurrent carcinoma of cervix uteri   |  |  |  |  |  |  |  |                          |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |                          |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |                          |  |  |  |
| 171X   |  |  |  |  |  |  |  |                          |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes                     |  |                          |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |                          |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town   |  | County                   |  | State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/1, 1968, to 4/17, 1968, that (I) (we) lost saw the deceased alive on 4/16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |                          |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |  | 22c. DATE SIGNED   |  |                          |  |  |  |
| John E. Adams  |  |  |  |  |  | 4/17/68  |  |                          |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |  |  |  |  |                          |  |  |  |
| John E. Adams, M.D.  |  | 6701 N. Charles Street   |  |  |  |  |  |                          |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town)   |  | (County)                 |  | (State)                                      |  |
| Burial   |  | 4/20/68.   |  | Gardens of Faith Cemetery  |  | Baltimore, Md.   |  |                          |  |  |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |                          |  |  |  |
| Leonard J. Ruck, Inc. Balto. Md. 21214   |  |  |  | APR 17 1968  |  | [Signature]  |  |                          |  |  |  |

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(15384)

Mr. John W. ...

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05380

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05382

|  |                  |  |  |   |                              |  |  |  |
|--|------------------|--|--|---|------------------------------|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <i>Clara (NMN) Schmidt</i>   |                  |  | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year <i>4/10 1968</i> |   |                              | 2b. HOUR OF ESTI-DEATH MATED <input type="checkbox"/> <i>4:30 P M</i>                        |  |  |
| 3. SEX <i>F</i>  | 4. RACE <i>W</i> | 5. DATE OF BIRTH <i>11/17/87</i>   | 6. AGE (in years last birthday) <i>80 YRS</i>                                      | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  | IF UNDER 24 HRS<br>HOURS MIN | 2c. DATE PRONOUNCED DEAD<br>Month <i>4</i> Day <i>10</i> Year <i>1968</i>                    |  |  |
| 7a. BIRTHPLACE (State or foreign country) <i>Livingston, Va</i>  |                  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        |                              | 9. COUNTY OF DEATH <i>Baltimore</i> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH <i>Bandallstown</i>  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Gen. Hosp</i>    |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>office work</i>  |                              | 12b. KIND OF BUSINESS OR INDUSTRY <i>Washinghouse</i>  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>   |                  | 13b. COUNTY <i>Balto</i>   |  | 13c. CITY OR TOWN <i>Bandallstown</i>   |                              | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER <i>Robson &amp; Liberty Road.</i>   |                  | 14. FATHER'S NAME First Middle Last <i>Guotar Schmidt</i>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Angelina Monted Oro</i>   |                              |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>   |                  | 16b. SOCIAL SECURITY NO. <i>579-10-9223</i>  |  | 17. INFORMANT <i>Florian H. Schmidt</i>   |                              | ADDRESS <i>9506 Liberty Road.</i>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Second &amp; Third Degree Burns</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>891X</i><br><i>85% Body Surface</i><br>DUE TO, OR AS A CONSEQUENCE OF<br><i>4 days</i><br>(c)                           |                  |  |  |   |                              |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Previous Radical Mastectomy - Left - 2yrs 2mo.</i>  |                  |  |  |   |                              |  |  |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |                              | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <i>10:30</i> P.M. <i>4/6 1968</i>              |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><i>Bed set on fire by patient at Nursing Home - CHADEL HILL NURSING-HOME</i> |                              |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK  |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Nursing Home</i> |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><i>Robson &amp; Liberty Rd. Bandallstown, Balto md.</i>   |                              |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |  |  |   |                              |  |  |  |
| ACTUAL SIGNATURE <i>James N. Frederick</i> M.D.  |                  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                              | 22b. DATE SIGNED <i>4/10/68</i>  |  |  |
| EXAMINER'S NAME (Type) <i>James N. Frederick</i>   |                  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                              | 1311 Francis Ave<br>Balto, 27 md.  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  |                  | 23b. DATE <i>4-13-68</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Wm. Hope Cemetery</i>   |                              | 23d. LOCATION (City or Town) (County) (State)<br><i>Cosecta, Wis.</i>                        |  |  |
| 24. FUNERAL DIRECTOR <i>Spring Byrne 8728 Liberty Road</i>   |                  |  |  | 25a. REC'D BY REGISTRAR <i>APR 15 1968</i>  |                              | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <span>05381</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH<br/>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>05383</span> </div>   |  |  |   |   |                                   |  |  |  |  |  |   |
|--|--|--|---|---|-----------------------------------|--|--|--|--|--|---|
| 1. DECEASED-NAME (Type or print) <b>Theresa S. SCHMIDT</b>   |  |  |   |   |                                   | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>24</b> Year <b>1968</b>                                   |  |  | 2b. HOUR <b>7:30AM</b>                             |  |   |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b>   |   | 5. DATE OF BIRTH <b>December 7, 1915</b>  |                                   |  | 6. AGE (In years lost birthday) <b>52</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>52</b> DAYS <b>0</b>  |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b> |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. COUNTY OF DEATH <b>Baltimore, Md.</b>   |  |  |  |  |   |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSPITAL</b> |   |                                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                  |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  |  | 13b. COUNTY <b>BALTO</b>  |   | 13c. CITY OR TOWN <b>Timonium</b> |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>1911 Lyden Rd. 21093</b> |  |   |
| 14. FATHER'S NAME First <b>Henry</b> Middle <b>J.</b> Last <b>Slagle</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME First <b>Sophia</b> Middle <b>M.</b> Last <b>Kabehlein</b>   |                                   |  |  |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)   |  |  |   | 16b. SOCIAL SECURITY NO.  |                                   | 17. INFORMANT Address <b>Mr Henry W. Schmidt 1911 Lyden Road 21093</b>                                   |  |  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4309 Massive brain hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>rupture of berry aneurysm of left communicating artery</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>331x</b>  |  |  |   |   |                                   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |   |                                   |  |  |  |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   |                                   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                   |  |  |  |  |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. <b>7620 York Rd.,</b>  |                                   | City or Town <b>Towson,</b>  |  | County <b>Md.</b>  |  | State <b>Md.</b>                             |   |
| 22a. I certify that <b>40</b> (this hospital) attended the deceased from <b>4/23/</b> , 19 <b>68</b> , to <b>4/24/</b> , 19 <b>68</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>4/24/</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |   |                                   |  |  |  |  |  |   |
| 22b. SIGNATURE <b>Reynaldo Orjuela-Gomez, M.D.</b>   |  | DEGREE <b>MD</b>   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |                                   | 22c. DATE SIGNED <b>April 24, 1968</b>   |  |  |  |  |   |
| 22d. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>   |  | 22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>                         |   |   |                                   |  |  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE <b>4-27-1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>  |                                   | 23d. LOCATION (City or Town) <b>Baltimore</b>  |  | (County) <b>Md.</b>  |  | (State) <b>Md.</b>                           |   |
| 24. FUNERAL DIRECTOR <b>Massahn Funeral Home 7401 Delair Road 21236</b>  |  |  |   | ADDRESS   |                                   | 25a. REC'D BY REGISTRAR <b>APR 29 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                      |  |  |   |

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• **Conclusion:**

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1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

Page 19 of 22

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 05382   |  |  |                              |  |  |  |  |                                    |                    | 05384   |  |  |   |                 |  |                  |  |  |  |  |  |  |  |  |
|---|--|--|------------------------------|--|--|--|--|------------------------------------|--------------------|---|--|--|---|-----------------|--|------------------|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                              |  |  |  |  |                                    |                    | CERTIFICATE OF DEATH  |  |  |   |                 |  |                  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print)  |  |  |                              |  | First Middle Last  |  |  |                                    |                    | 2a. DATE OF DEATH   |  |  |   |                 | 2b. HOUR   |                  |  |  |  |  |  |  |  |  |
| MANUEL  |  |  |                              |  | SCHNIDER   |  |  |                                    |                    | APRIL 7, 1968   |  |  |   |                 | 9:25 AM  |                  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  | 4. RACE                      |  |  | 5. DATE OF BIRTH   |  |                                    |                    |   | 6. AGE (In years last birthday)  |  |   | IF UNDER 1 YEAR |  | IF UNDER 24 HRS. |  |  |  |  |  |  |  |  |
| MALE  |  |  | WHITE                        |  |  | JULY 31, 1894  |  |                                    |                    |   | 73 YRS.  |  |   | MONTHS DAYS     |  | HOURS MIN.       |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY? |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                    | 9. COUNTY OF DEATH |   |  |  |   |                 |  |                  |  |  |  |  |  |  |  |  |
| RUSSIA  |  |  | U.S.A.                       |  |  |  |  |                                    | BALTIMORE          |   |  |  |   |                 |  |                  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |                              |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |                                    |                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  |   |                 | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                  |  |  |  |  |  |  |  |  |
| RANDALLSTOWN  |  |  |                              |  | BALTO. CO. GEN. HOSP.  |  |  |                                    |                    | MERCHANT  |  |  |   |                 | INSTALLMENT  |                  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |                              |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN                  |                    |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                        |                 |  |                  |  |  |  |  |  |  |  |  |
| MARYLAND  |  |  |                              |  |  |  |  | BALTIMORE                          |                    |   |  |  | 6801 PARK HGHTS. AVE.                         |                 |  |                  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |                              |  | 15. MOTHER'S MAIDEN NAME   |  |  |                                    |                    |   |  |  |   |                 |  |                  |  |  |  |  |  |  |  |  |
| MAISHE  |  |  |                              |  | SCHNIDER   |  |  |                                    |                    | SARAH   |  |  |   |                 | ?  |                  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  |  |                              |  | 16b. SOCIAL SECURITY NO.   |  |  |                                    |                    | 17. INFORMANT   |  |  |   |                 | Address  |                  |  |  |  |  |  |  |  |  |
| NO  |  |  |                              |  | 216-01-2951A   |  |  |                                    |                    | MRS. MINNIE SCHNIDER  |  |  |   |                 | 6801 PARK HEIGHTS AVE. #21215  |                  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |                              |  |  |  |  |                                    |                    |   |  |  |   |                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |                  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |                              |  |  |  |  |                                    |                    |   |  |  |   |                 |  |                  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Carcinoma of the lung   |  |  |                              |  |  |  |  |                                    |                    |   |  |  |   |                 | 3 years  |                  |  |  |  |  |  |  |  |  |
| 1621 DUE TO, OR AS A CONSEQUENCE OF   |  |  |                              |  |  |  |  |                                    |                    |   |  |  |   |                 |  |                  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |                              |  |  |  |  |                                    |                    |   |  |  |   |                 |  |                  |  |  |  |  |  |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |  |  |                              |  |  |  |  |                                    |                    |   |  |  |   |                 |  |                  |  |  |  |  |  |  |  |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF  |  |  |                              |  |  |  |  |                                    |                    |   |  |  |   |                 |  |                  |  |  |  |  |  |  |  |  |
| (d) DUE TO, OR AS A CONSEQUENCE OF  |  |  |                              |  |  |  |  |                                    |                    |   |  |  |   |                 |  |                  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |                              |  |  |  |  |                                    |                    |   |  |  |   |                 |  |                  |  |  |  |  |  |  |  |  |
| 163X  |  |  |                              |  |  |  |  |                                    |                    |   |  |  |   |                 |  |                  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |                                    |                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  |  |   |                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |                              |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |                                    |                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |  |   |                 |  |                  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |                              |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |                                    |                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |  |  |   |                 |  |                  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-3, 1967, to 4-7, 1968, that (I) (we) last saw the deceased alive on 4-7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                              |  |  |  |  |                                    |                    |   |  |  |   |                 |  |                  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |                              |  |  |  |  |                                    |                    |   |  |  |   |                 | 22c. DATE SIGNED   |                  |  |  |  |  |  |  |  |  |
| Joseph C. Matchar DEGREE  |  |  |                              |  |  |  |  |                                    |                    |   |  |  |   |                 | 4/8/68   |                  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |                              |  |  |  |  |                                    |                    |   |  |  |   |                 | 22e. ADDRESS   |                  |  |  |  |  |  |  |  |  |
| X JOSEPH MATCHAR  |  |  |                              |  |  |  |  |                                    |                    |   |  |  |   |                 | 6821 REISTERSTOWN ROAD   |                  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |                              |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY |                    |   |  |  | 23d. LOCATION (City or Town) (County) (State) |                 |  |                  |  |  |  |  |  |  |  |  |
| BURIAL  |  |  |                              |  | 4-8-68   |  |  | BETH EL MEMORIAL PARK              |                    |   |  |  | RANDALLSTOWN, MD.                             |                 |  |                  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |                              |  | ADDRESS  |  |  |                                    |                    | 25a. REC'D BY REGISTRAR   |  |  |   |                 | 25b. REGISTRAR'S SIGNATURE   |                  |  |  |  |  |  |  |  |  |
| SOL LEVINSON & BROS., 6010 REISTERSTOWN   |  |  |                              |  | RD.  |  |  |                                    |                    | DATE  |  |  |   |                 | APR 10 1968  |                  |  |  |  |  |  |  |  |  |

05888

OFFICE OF STATE

05888

*[Faint, mostly illegible text, possibly a letter or official document, spanning the main body of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 410-44  
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print)   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |  |  |
| HOWARD   |  |  | SCHROTH Sr.  |  |  | APRIL Month 27, Day 1968 Year  |  |  | 3:55 AM  |  |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (In years last birthday)  |  |  |
| MALE   |  |  | WHITE  |  |  | NOVEMBER 5, 1903   |  |  | 64 YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  | 9. COUNTY OF DEATH   |  |  |
| MARYLAND   |  |  | U.S.A.   |  |  | BALTIMORE, Md.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| TOWSON   |  |  | ST. JOSEPH HOSPITAL  |  |  |  |  |  | GAS & ELEC.  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| MARYLAND   |  |  | BALTIMORE  |  |  |  |  |  | 3123 TEXAS AVE. #21234   |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |
| First Middle Last  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |
| Charles Schroth  |  |  | unknown  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT  |  |  | Address  |  |  |
| No   |  |  | 212-05-4558  |  |  | Mr Howard A. Schroth Jr.   |  |  | 21220 4D. Alder Drive  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION  |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |
| ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE  |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |  |  |  |  |  |  |  |  |  |  |
| 4201   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from APRIL 15, 1968, to APRIL 27, 1968, that (X) (we) lost saw the deceased alive on APRIL 27, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |
| EDUARDO MONTELIBANO, M.D.  |  |  |  |  |  |  |  |  | APRIL 27, 1968   |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |
| EDUARDO MONTELIBANO, M.D.  |  |  |  |  |  |  |  |  | 7620 YORK ROAD TOWSON, MD. #21204  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |
| Burial   |  |  | 4-30-1968  |  |  | St. John's Cemetery  |  |  | Parkville Balto. Md.   |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |
| Lassahn Funeral Home 7401 Belair Road 21204  |  |  |  |  |  | APR 29 1968  |  |  | Richard Judge  |  |  |

4222



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| <div style="display: flex; justify-content: space-between;"> <span>05384</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>05386</span> </div>   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                      |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|---|--|--|--------------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br>Lena  |  |  | Middle<br>Seidel  |  |  | Last<br>Seidel  |  |  | 2a. DATE OF DEATH<br>Month<br>April<br>Day<br>20<br>Year<br>1968  |  |  | 2b. HOUR<br>4:25 P                   |  |  |
| 3. SEX<br>Female   |  |  | 4. RACE<br>White   |  |  | 5. DATE OF BIRTH<br>Sept. 4, 1887   |  |  | 6. AGE (In years last birthday)<br>80 YRS.  |  |  | 7. IF UNDER 1 YEAR<br>MONTHS<br>DAYS  |  |  | 8. IF UNDER 24 HRS.<br>HOURS<br>MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |   |  |  |                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>711 Old North Point Road |  |  |   |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Machine Operator-Continental Can |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |                                      |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  |  | 13b. COUNTY<br>Baltimore   |  |  | 13c. CITY OR TOWN<br>Dundalk  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  |  | 13e. STREET AND NUMBER<br>711 Old North Pt. Rd.   |  |  |                                      |  |  |
| 14. FATHER'S NAME<br>First<br>Frederick  |  |  | Middle<br>Porsinger  |  |  | Last<br>Porsinger   |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Mary   |  |  | Middle<br>S.  |  |  | Last<br>Walton                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br>215-01-8357  |  |  | 17. INFORMANT (Sister)<br>Mrs. Ida Filliaux, 711 Old North Pt. Rd.  |  |  |   |  |  |   |  |  |                                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br><u>410.0</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>C. V. R. Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>48 hours</u><br><u>20 years</u>  |  |  |                                      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>4201</u>   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                      |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |                                      |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |   |  |  |                                      |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |   |  |  |   |  |  |                                      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/18</u> , 19 <u>68</u> , to <u>4/20</u> , 19 <u>68</u> that (I) (we) last saw the deceased alive on <u>4/20</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                           |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                      |  |  |
| 22b. SIGNATURE<br><u>Morris A. Jacobs M.D.</u> DEGREE  |  |  |  |  |  |   |  |  |   |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br>4/22/68          |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Morris A. Jacobs M.D.  |  |  |  |  |  | 22e. ADDRESS<br>1010 Old North Point Rd. Dundalk, Md.   |  |  |   |  |  |   |  |  |                                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>4/24/68   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland  |  |  |   |  |  |                                      |  |  |
| 24. FUNERAL DIRECTOR<br>John J. Duda, 7922 Wise Ave. Dundalk, Md.  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE APR 24 1968   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |   |  |  |                                      |  |  |



7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1 (M)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  | 05385   |  |   |  | 05387   |  |  |  |   |  |
|--|--|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>CARL</b> <b>WILHELM</b> <b>SEILER</b>   |  |  |  | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>5</b> Year <b>1968</b>   |  |   |  | 2b. HOUR<br><b>4:20 PM</b>  |  |  |  |   |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>Ca</b>   |  | 5. DATE OF BIRTH<br><b>2/21/89</b>  |  |   |  | 6. AGE (In years last birthday)<br><b>79</b> YRS.                                   |  | IF UNDER 1 YEAR<br>MONTHS <b>7</b> DAYS <b>9</b> |  | IF UNDER 24 HRS.<br>HOURS <b>4</b> MIN. <b>20</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>GERMANY</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> County Md.   |  |   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Greater Baltimore Med. Center</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)         |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>1218 Walker Ave</b>                                    |  |  |  |   |  |
| 14. FATHER'S NAME<br>First <b>Baltasar</b> Middle <b>C</b> Last <b>Seiler</b>  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Zimmer</b> Middle <b>?</b> Last <b>?</b>  |  |   |  |   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>213-10-0345</b>   |  | 17. INFORMANT<br>Address <b>FREDA SEILER 1218 WALKER AVE</b>  |  |   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic and hypertensive</b><br><b>4120</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>443 X</b>  |  |  |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>yes</b>  |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |  |   |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State                                 |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-4, 1968</b> , to <b>4-5, 1968</b> , that (I) (we) lost saw the deceased alive on <b>4-5, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>J. A. DeCastro</b>  |  |  |  |   |  |   |  |   |  |  |  | 22c. DATE SIGNED<br><b>4-5-68</b>                 |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. J.A. DeCastro</b>   |  | 22e. ADDRESS<br><b>KBMC</b>  |  |   |  |   |  |   |  |  |  |   |  |
| 23a. (BURIAL) CREMATION, REMOVAL, etc.<br><b>REMOVED</b>   |  | 23b. DATE<br><b>4-8-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>   |  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cockeysville, Md. Baltimore</b> |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, Towson, Md. 21204</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 11 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. J...</b>  |  |   |  |  |  |   |  |

12326

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |   |   |  |  |
|--|--|--|--|--|--|---|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |   |   |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last<br>WILLIAM CHARLES SEITZ   |  |  | 20. DATE OF DEATH<br>Month Day Year<br>APRIL 30 1968  |   | 2b. HOUR<br>4:55 P.M.                                   |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>1/11/88  |  | 6. AGE (In years last birthday)<br>80 YRS.  |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                       |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE COUNTY, Md.   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>FORT HOWARD   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>VET. ADM. HOSPITAL |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>SPLICER TESTER |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>TELEPHONE CO.      |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MARYLAND  |  |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>1558 GALENA ROAD |  |
| 14. FATHER'S NAME<br>First Middle Last<br>HENRY SEITZ  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>MARY HAMILTON                                     |  |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>YES   |  |  | 16b. SOCIAL SECURITY NO.<br>WW I<br>212 20 87 05   |  | 17. INFORMANT<br>Address<br>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.               |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMA OF RIGHT UPPER LOBE OF LUNG</u><br><u>1621</u> <u>X DUE TO OR AS A CONSEQUENCE OF</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE WITH DECOMPENSATION</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><u>1621</u>  |  |  |  |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>NO AUTOPSY              |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State  |  |   |   |   |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>3/4/68</u> , 19 <u>68</u> , to <u>4/30/68</u> , 19 <u>68</u> , that (b) (we) last saw the deceased alive on <u>4/30/68</u> , 19 <u>68</u> , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |   |   |  |  |
| 22b. SIGNATURE<br><u>Ahmed Kutty MD</u>  |  |  |  | 22c. DATE SIGNED<br>5/1/68   |  |   |   |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>AHMED C. K. KUTTY, M. D.   |  |  |  | 22e. ADDRESS<br>VAH FORT HOWARD, MARYLAND  |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  | 23b. DATE<br>5/3/68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE NATIONAL   |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MARYLAND                                      |   |   |  |  |
| 24. FUNERAL DIRECTOR<br><u>Fredrick D. Miller</u>  |  |  |  | ADDRESS<br>MILLER FUNERAL HOME<br>3019 E. Monument Street  |  | 25. RECEIVED BY<br>NAY 2 1968   |   | 25b. SIGNATURE<br><u>Fredrick D. Miller</u>             |  |  |

02884

02884

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HONOLULU, HAWAII

TO: DIRECTOR, U.S. AIR FORCE  
FROM: SAC, HONOLULU (100-100000)  
SUBJECT: [Illegible]

RE: [Illegible]  
DATE: [Illegible]

1. [Illegible]  
2. [Illegible]  
3. [Illegible]

4. [Illegible]  
5. [Illegible]  
6. [Illegible]

7. [Illegible]  
8. [Illegible]  
9. [Illegible]

10. [Illegible]  
11. [Illegible]  
12. [Illegible]

13. [Illegible]  
14. [Illegible]  
15. [Illegible]

16. [Illegible]  
17. [Illegible]  
18. [Illegible]

19. [Illegible]  
20. [Illegible]  
21. [Illegible]

22. [Illegible]  
23. [Illegible]  
24. [Illegible]

*James K. [Illegible]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05387 CERTIFICATE OF DEATH 05389

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>                |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Providence (Towson 21204)</u>   |                                  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Providence (Towson 21204)</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>1000 Roxleigh Road</u>  |                                  | d. STREET ADDRESS<br><u>1000 Roxleigh Road</u>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Anna</u> Middle <u>Carson</u> Last <u>Shepard</u>  |                                  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>18</u> Year <u>1968</u>   |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>March 9, 1875</u> |
| 9. AGE (In years last birthday)<br><u>93</u> yrs.  |                                  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Pittsburgh, Penna.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Joseph McCall</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Maria Lambert</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u> <u>None</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>086-07-38300</u>  |  |
| 17. INFORMANT<br><u>Miss Elizabeth Shephard</u>  |                                  | Address <u>Towson, Md.</u><br><u>1000 Roxleigh Rd.</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4129 Congestive Heart Failure</u><br>DUE TO (b) <u>Arterio-sclerotic Heart Disease</u><br>DUE TO (c) <u>  </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>22 yrs</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>4200</u>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>  </u> <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May, 1965</u> to <u>April, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 16, 1968</u> , and that death occurred at <u>2 a.m.</u> from the causes and on the date stated above.   |                                  |   |  |
| 22a. SIGNATURE<br><u>Francis T. Daly</u>   |                                  | 22b. DATE SIGNED<br><u>4/19/68</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>FRANCIS T. DALY</u>   |                                  | 22d. ADDRESS<br><u>3201 N. CHARLES ST</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal/Burial April 22, 1968</u>  |                                  | 23b. DATE THEREOF<br><u>April 22, 1968</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Sharon Memorial Park</u>  |                                  | 23d. LOCATION (City, town or county) (State)<br><u>Charlotte, North Carolina</u>  |  |
| 24. FUNERAL DIRECTOR<br><u>John Burns' Sons, Towson, Maryland</u>  |                                  | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |                                  | DATE<br><u>APR 23 1968</u>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  | 05390  |  |                                   |  |   |  |   |  |  |  |
|---|--|--|--|---|--|--|--|--|--|-----------------------------------|--|---|--|---|--|--|--|
| 05388   |  |  |  | CERTIFICATE OF DEATH  |  |  |  |  |  |                                   |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br>Emma  |  | Middle<br>M.  |  | Last<br>Sherman  |  | 2a. DATE OF DEATH<br>Month<br>April  |  | Day<br>7                          |  | Year<br>68  |  | 2b. HOUR<br>6.00PM  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>4-25-1895   |  |  |  | 6. AGE (In years<br>last birthday)<br>72 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS |  | IF UNDER 24 HRS.<br>HOURS<br>MIN  |  |   |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |  |  |  |                                   |  |   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>St. Joseph Hospital |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland |  | 13b. COUNTY<br>Baltimore          |  | 13c. CITY OR TOWN<br>Lutherville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>1016 Adcock Rd.                |  |
| 14. FATHER'S NAME<br>First<br>?   |  | Middle<br>Lund   |  | Last<br>?   |  | 15. MOTHER'S MAIDEN NAME<br>First<br>?   |  | Middle<br>?  |  | Last<br>?                         |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>No |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Mrs. Anthony Campanaro, 1016 Adcock Rd. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral vascular hemorrhage</u><br>431.9<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>331X |  |  |  |   |  |  |  |  |  |                                   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                                      |  |                                   |  |   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |                                   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                        |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |                                   |  |   |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 4/2/1968, to 4/7/1968, that (we) last<br>saw the deceased alive on 4/7/1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |                                   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Lillian   |  | 22c. DATE SIGNED<br>April 8, 1968  |  | 22d. PHYSICIAN'S<br>NAME (Type)<br>Ines Cilliani, M.D.  |  |  |  |  |  |                                   |  |   |  |   |  |  |  |
| 22e. ADDRESS<br>7620 York Rd., Towson Md.,  |  | 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  |   |  |  |  |  |  |                                   |  |   |  |   |  |  |  |
| 23b. DATE<br>4-10-68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy redeemer  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.   |  | 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson, Towson, Md. 21204                    |  |  |  |                                   |  |   |  |   |  |  |  |
| 25a. REC'D BY REGISTRAR<br>DATE APR 11 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Jupp   |  |   |  |  |  |  |  |                                   |  |   |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 05388   |  |  |                     |  |  |   |  |   |  |  |  | 05391  |  |  |                                |  |  |   |  |  |  |  |  |                        |  |  |  |  |  |
|---|--|--|---------------------|--|--|---|--|---|--|--|--|--|--|--|--------------------------------|--|--|---|--|--|--|--|--|------------------------|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                     |  |  |   |  |   |  |  |  | CERTIFICATE OF DEATH   |  |  |                                |  |  |   |  |  |  |  |  |                        |  |  |  |  |  |
| Item 6 Film G399 4/22/68 kk   |  |  |                     |  |  |   |  |   |  |  |  |  |  |  |                                |  |  |   |  |  |  |  |  |                        |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <u>Katherine Rebecca Sima</u>   |  |  |                     |  |  | 2a. DATE OF DEATH<br>Month <u>4</u> Day <u>10</u> Year <u>68</u>                            |  |   |  |  |  | 2b. HOUR<br><u>10</u> M  |  |  |                                |  |  |   |  |  |  |  |  |                        |  |  |  |  |  |
| 3. SEX<br><u>F</u>  |  |  | 4. RACE<br><u>C</u> |  |  | 5. DATE OF BIRTH<br><u>8-14-99</u>  |  |   |  |  |  | 6. AGE (In years last birthday)<br><u>67</u> YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS |  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |  |  |  |  |                        |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><u>New Hampshire</u>   |  |  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH<br><u>Balto</u> Md.   |  |  |                                |  |  |   |  |  |  |  |  |                        |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Portsmouth N.H.</u>   |  |  |                     |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>GBMC</u> |  |   |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>House wife</u>                           |  |  |                                |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |                        |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><u>146 Newfield Rd</u>   |  |  |                     |  |  | 13b. COUNTY<br><u>Balto</u>   |  |   |  |  |  | 13c. CITY OR TOWN<br><u>County</u>   |  |  |                                |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  | 13e. STREET AND NUMBER |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><u>Thomas Freeman Freeman</u>  |  |  |                     |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><u>Ann Ida Freeman</u>                        |  |   |  |  |  |  |  |  |                                |  |  |   |  |  |  |  |  |                        |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)   |  |  |                     |  |  | 16b. SOCIAL SECURITY NO.<br><u>101-24-6481</u>  |  |   |  |  |  | 17. INFORMANT<br>Address<br><u>Wm. R. Sima, Jr., son, above</u>  |  |  |                                |  |  |   |  |  |  |  |  |                        |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Tetanus Ca of Partur &amp; labor</u><br><u>1420</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                            |  |  |                     |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>15 yrs.</u>   |  |  |                                |  |  |   |  |  |  |  |  |                        |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>1420</u>   |  |  |                     |  |  |   |  |   |  |  |  |  |  |  |                                |  |  |   |  |  |  |  |  |                        |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |                                |  |  |   |  |  |  |  |  |                        |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  |                     | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |                                |  |  |   |  |  |  |  |  |                        |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |                     | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |                                |  |  |   |  |  |  |  |  |                        |  |  |  |  |  |
| 22a. I certify that <del>the</del> (this hospital) attended the deceased from <u>3/22</u> , 19 <u>68</u> , to <u>4/10</u> , 19 <u>68</u> , that <del>the</del> (we) last saw the deceased alive on <u>4/10</u> , 19 <u>68</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>the</del> (we) (did) <del>not</del> view the body after death. |  |  |                     |  |  |   |  |   |  |  |  |  |  |  |                                |  |  |   |  |  |  |  |  |                        |  |  |  |  |  |
| 22b. SIGNATURE<br><u>P. L. H. P. S. A. M.D.</u>   |  |  |                     |  |  |   |  |   |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |  |                                | 22c. DATE SIGNED<br><u>4/10/68</u>                 |  |   |  |  |  |  |  |                        |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>P. L. H. P. S. A. M.D.</u>   |  |  |                     |  |  | 22e. ADDRESS<br><u>6701 N. Charles St.</u>  |  |   |  |  |  |  |  |  |                                |  |  |   |  |  |  |  |  |                        |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |  |                     | 23b. DATE<br><u>4/13/68</u>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lake View Mem. Park</u>  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Carroll County, Md.</u>  |  |  |                                |  |  |   |  |  |  |  |  |                        |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Schimunek Funeral Home, Inc.</u><br><u>3331 Brehms Lane</u>  |  |  |                     |  |  |   |  |   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><u>APR 15 1968</u>  |  |  |                                | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |  |   |  |  |  |  |  |                        |  |  |  |  |  |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV. 1/68

| 1. DECEASED-NAME<br>(Type or print)   |         | First  | Middle   | Last   | 2a. DATE OF DEATH   |   |  | 2b. HOUR |                                   |  |  |
|---|---------|--|--|--|---|---|--|----------|-----------------------------------|--|--|
| HARRY LEONARD SINGLETON   |         |  |  |  | Month   | Day   | Year   | 1:45 PM  |                                   |  |  |
| 3. SEX  | 4. RACE |  | 5. DATE OF BIRTH   |  | 6. AGE (In years lost birthday)   |   | 7. IF UNDER 1 YEAR MONTHS DAY  |          | 8. IF UNDER 24 HRS. HOURS MIN.    |  |  |
| male  | WHITE   |  | 1/28/60  |  | 68 YRS.   |   | 2/16   |          |                                   |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |          |                                   |  |  |
| VIRGINIA  |         | U.S.A.   |  |  |   | Baltimore County, Md.   |  |          |                                   |  |  |
| 10. CITY OR TOWN OF DEATH   |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |          | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Mt. Wilson  |         |  | Mt. Wilson State Hosp.   |  |   | JANITOR   |  |          |                                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          | 13e. STREET AND NUMBER            |  |  |
| MARYLAND  |         |  | CARROLL  |  |   |   |  |          | NEW WINDSOR                       |  |  |
| 14. FATHER'S NAME First Middle Last   |         |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |   |   |  |          |                                   |  |  |
| DAVE SINGLETON  |         |  |  | ANNA SMITH   |   |   |  |          |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |   |   |  |          |                                   |  |  |
| NO  |         | 172-18-0150  |  | Records, Mt. Wilson State Hospital   |   |   |  |          |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |  |  |   |   |  |          |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA RIGHT UPPER LOBC   |         |  |  |  |   |   |  |          |                                   | 7 months                                     |  |
| 1621  |         |  |  |  |   |   |  |          |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |         |  |  |  |   |   |  |          |                                   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |         |  |  |  |   |   |  |          |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |         |  |  |  |   |   |  |          |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |  |  |  |   |   |  |          |                                   |  |  |
| 163X  |         |  |  |  |   |   |  |          |                                   |  |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |          |                                   |  |  |
|   |         |  |  |  |   |   |  |          |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |         | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |          |                                   |  |  |
|   |         |  |  |  |   |   |  |          |                                   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |   | City or Town  |  | County   |                                   | State  |  |
|   |         |  |  |  |   |   |  |          |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/5, 1967, to 4/12, 1968, that (I) (we) last saw the deceased alive on 4/12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         |  |  |  |   |   |  |          |                                   |  |  |
| 22b. SIGNATURE  |         |  |  |  |   |   |  |          |                                   | 22c. DATE SIGNED                             |  |
| W Newcomer  |         |  |  |  |   |   |  |          |                                   | 4/12/68                                      |  |
| 22d. PHYSICIAN'S NAME (Type)  |         |  |  |  | 22e. ADDRESS  |   |  |          |                                   |  |  |
| William Newcomer, M.D.  |         |  |  |  | Mount Wilson, Maryland  |   |  |          |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town)  |  | (County) |                                   | (State)                                      |  |
| BURIAL  |         | 4/15/68  |  | PRESBYTERIAN   |   | NEW WINDSOR   |  |          |                                   | MD   |  |
| 24. FUNERAL DIRECTOR ADDRESS  |         |  |  |  | 25a. REC'D BY REGISTRAR DATE  |   | 25b. REGISTRAR'S SIGNATURE   |          |                                   |  |  |
| J. Hartzler & Sons New Windsor  |         |  |  |  | APR 16 1968   |   | Charles Judge  |          |                                   |  |  |

MEDICAL CERTIFICATION

E. K. Hartzler

2

# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(Type or Print) <u>ELLA First Vaughan Sioussat</u> Last <u>SOUSSAT</u>   |  |   |  |   |  | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <u>April 13 1968</u>   |  |   | 2b. HOUR<br>M  |   |  |
| 3. SEX<br><u>Female</u>  |  | 4. RACE<br><u>White</u>   |  | 5. DATE OF BIRTH<br><u>Nov 26, 1894</u>   |  | 6. AGE (In years last birthday)<br><u>74 yrs.</u>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS                                       |  |
| 7a. BIRTHPLACE (State or foreign country)<br><u>Tennessee</u>  |  |   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><u>Baltimore County</u> Md.     |  |
| 10. CITY OR TOWN OF DEATH<br><u>Near Jacksonville, Md.</u>   |  |   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>Garrettsville Pk &amp; Manor Rd.</u> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>Housewife</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>  |  |   |  | 13b. COUNTY<br><u>Balto. City</u>   |  | 13c. CITY OR TOWN<br><u>Baltimore</u>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><u>702 Gladstone Avenue</u> |  |
| 14. FATHER'S NAME First <u>Dr. George Patterson</u> Middle <u></u> Last <u></u>  |  |   |  | 15. MOTHER'S MAIDEN NAME First <u>Mary</u> Middle <u>Vaughan</u> Last <u></u>   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><u>None</u>   |  | 17. INFORMANT ADDRESS<br><u>Stuart G. Garrett, 517 E 84th St., New York, N.Y.</u>                       |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>SKULL FRACTURE</u><br>(b) <u></u><br>DUE TO, OR AS A CONSEQUENCE OF <u></u><br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>1254</u>   |  |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><u>4/13 1968</u>   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><u>AUTO ACCIDENT</u>   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY Month, Day, Year<br><u>5 HOUR A.M. 4/13 1968</u>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)<br><u>AUTO ACCIDENT</u> |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><u>STREET</u> |  | 21f. LOCATION Street or R.F.D. No.<br><u>JARRETSVILLE PIKE - MANOR RD</u>   |  | City or Town<br><u>BALTO.</u>   |  | County<br><u>MD</u>   |  | State   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <u>William A. Piusbury</u> M.D.   |  |   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   | 22b. DATE SIGNED<br><u>4/13/68</u>                                 |   |  |
| EXAMINER'S NAME (Type) <u>William A. Piusbury</u>  |  |   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   | ADDRESS (Street, city, town, or county)<br><u>Towson, Maryland</u> |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u>  |  | 23b. DATE<br><u>Apr. 15, 1968</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Greenmount Cemetery</u>  |  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Maryland</u>   |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>John Burns' Sons, Towson, Maryland</u>  |  |   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>APR 17 1968</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |   |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-200. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05392

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05394

|   |                         |  |   |   |   |   |  |  |
|---|-------------------------|--|---|---|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>STEPHANIE (or STELLA) B. SLONSKI</b>   |                         |  | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> <b>4-21-68</b>    |   |   | 2b. HOUR <b>—</b> M   |  |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>10/5/1920</b>   | 6. AGE (In years last birthday)<br><b>47</b> YRS                                    | IF UNDER 1 YEAR<br>MONTHS <b>—</b> DAYS <b>—</b>  | IF UNDER 24 HRS<br>HOURS <b>—</b> MIN. <b>—</b>   | 2c. DATE PRONOUNCED DEAD<br>Month <b>April</b> Day <b>21</b> Year <b>1968</b> |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                    |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>8324 Bletzer Road</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>at home</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b><br><b>8324 Bletzer Road</b>  |                         |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Dundalk</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>8324 Bletzer Road</b>  |                         |  |   |   |   |   |  |  |
| 14. FATHER'S NAME<br>First <b>Alexander</b> Middle <b>Kiwakowski</b> Last <b>Kocur</b>  |                         |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Mary</b> Middle <b>Kocur</b> Last <b>Kocur</b> |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-2191</b>                                      |   | 17. INFORMANT<br><b>Ben P. Slonski, husband, (above)</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>A-S-C-V- Disease</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                       |                         |  |   |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4221 Diabetes Mellitus</b>  |                         |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M.   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                             |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |   |   |   |   |  |  |
| ACTUAL SIGNATURE<br><b>Melvin B. Davis, M. D.</b>   |                         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                     |   |   | 22b. DATE SIGNED<br><b>April 23, 1968</b>                                     |  |  |
| EXAMINER'S NAME (Type)  |                         |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                 |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                   |  |  |
|   |                         |  | ADDRESS (Street, city, town, or county)<br><b>6800 Mornington Rd.</b>               |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>4/24/68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem.</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>         |  |  |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>  |                         |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 24 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. J...</b>                          |  |  |

0022-0272/97/0000-0000\$05.00/0



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15-10  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|  |  |   |                     |   |  |   |  |  |
|--|--|---|---------------------|---|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>CHARLES</b>   |  | First <b>A.</b>   | Middle <b>SMITH</b> | Last  | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>11</b> Year <b>68</b> |   | 2b. HOUR<br><b>10:45 AM</b>                      |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>NEGRO</b>   |                     | 5. DATE OF BIRTH<br><b>11/27/22</b>   |  | 6. AGE (In years last birthday)<br><b>45</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b>            |
| 7a. BIRTHPLACE (State or foreign)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY,</b>  |  | Md.  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET. ADM. HOSPITAL</b> |                     | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>MECHANIC</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GARAGE</b>  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>HOWARD</b>  |                     | 13c. CITY OR TOWN<br><b>ELLICOTT CITY</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>75 NEW CUT ROAD</b>           |
| 14. FATHER'S NAME<br>First <b>AMOS SMITH</b>   |  | Middle  | Last                | 15. MOTHER'S MAIDEN NAME<br>First <b>VIOLA</b>  |  | Middle  | Last <b>BENTLEY</b>                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input checked="" type="checkbox"/> no, or unknown <input type="checkbox"/> (If yes give war or dates of service)<br><b>WW I</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218 16 00 30</b>   |                     | 17. INFORMANT<br>Address<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE PONTINE, RECENT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE,</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIOSCLEROSIS GENERALIZED, OLD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>4427</b> |  |   |                     |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>OLD</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>ANEURYSM BASILAR ARTERY</b>   |  |   |                     |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                     | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>                 |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |                     | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                              |                     | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |
| 22a. I certify that <b>(H)</b> (this hospital) attended the deceased from <b>4/9/68</b> , 19____, to <b>4/11/68</b> , 19____, that <b>(H)</b> (we) last saw the deceased alive on <b>4/11/68</b> , 19____, and that in <b>(H)</b> (our) opinion death occurred on the date and hour and from the causes stated above <b>(H)</b> (we) (did) (did not) view the body after death.  |  |   |                     |   |  |   |  |  |
| 22b. SIGNATURE<br><b>John D. Talbert MD</b>  |  | DEGREE<br><b>JOHN D. TALBERT, M. D.</b>   |                     | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>4/11/68</b>  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |                     |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4/16/68</b>   |                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                     |  |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS<br><b>NUTTER FUNERAL HOME</b><br><b>3035 W. North Avenue, Baltimore, Md.</b>                      |                     | 25a. REG. BY REGISTRAR<br><b>APR 15 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                      |   |   |  |  |  |  |  |
|---|----------------------|---|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>HARRY M. SMITH</b>   |                      |   | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 4-28 1968   |  |  | 2b. HOUR <b>6:45</b> M   |  |  |
| 3. SEX <b>MALE</b>  | 4. RACE <b>WHITE</b> | 5. DATE OF BIRTH <b>DEC 12-1885</b>   | 6. AGE (In years last birthday) <b>82</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>               | 2c. DATE PRONOUNCED DEAD<br>Month <b>APR</b> Day <b>28</b> Year <b>1968</b>                          |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>BALTIMORE</b> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH <b>DUNDALK</b>  |                      |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7313 HOLDBIRD</b>   |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CLERK</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>STORE</b>           |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>   |                      |   | 13b. COUNTY <b>BA</b>   |  | 13c. CITY OR TOWN <b>BALTIMORE</b>                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         | 13e. STREET AND NUMBER <b>2037 FLEET ST</b>                                      |  |
| 14. FATHER'S NAME First <b>JAMES</b> Middle <b>SMITH</b> Last <b>SMITH</b>  |                      |   | 15. MOTHER'S MAIDEN NAME First <b>REBECCA</b> Middle <b>EVERETT</b> Last <b>EVERETT</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |                      |   | 16b. SOCIAL SECURITY NO. <b>213-48-5456</b>   |  | 17. INFORMANT ADDRESS <b>MRS BESSIE V. BAUER 7313 HOLDBIRD</b> |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>A-S-C-V-Disease</b><br>4129<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Due to, or as a consequence of, Sclerotic</b><br>(b) <b>Due to, or as a consequence of, Sclerotic</b><br>(c) <b>Sclerotic</b>  |                      |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>—</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4221</b>  |                      |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>4/22/68</b>   |                      |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>None</b>   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      | 21b. TIME OF INJURY Month, Day, Year <b>4-19</b> HOUR A.M. <b>—</b> P.M. <b>—</b> |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |                      | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)      |   | 21f. LOCATION Street or R.F.D. No. <b>—</b> City or Town <b>—</b> County <b>—</b> State <b>—</b>   |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                      |   |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>M.B. Davis</b>  |                      |   | M.D. <b>M.B. DAVIS M.D.</b>   |  |  | 22b. DATE SIGNED <b>4/29/68</b>  |  |  |
| EXAMINER'S NAME (Type) <b>M.B. DAVIS</b>  |                      |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |  | ADDRESS (Street, city, town, or county) <b>DUNDALK MD</b>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                      | 23b. DATE <b>5/1/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>HOLY REPEMER</b>   |  | 23d. LOCATION (City or Town) <b>BALTIMORE</b> (County) <b>MD</b> (State) <b>MD</b>                   |  |  |
| 24. FUNERAL DIRECTOR <b>ULLRICH FUNERAL HOME-DUNDALK MD</b>   |                      |   |   | ADDRESS <b>—</b>   |  | 25a. REC'D BY REGISTRAR <b>MAY 01 1968</b> DATE <b>—</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>          |

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

28330

FOR SALE  
WEIGHT 100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MD  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|   |  |   |  |   |  |   |   |  |                                      |   |  |
|---|--|---|--|---|--|---|---|--|--------------------------------------|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Joseph Brown Smith, Sr   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>4 27 68 |   |  | 2b. HOUR<br>7:40 aM   |   |  |                                      |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>NEGRO  |  | 5. DATE OF BIRTH<br>7/4/17  |  | 6. AGE (In years<br>last birthday)<br>50 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |                                      | IF UNDER 24 HRS.                                |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>ANNAPOLIS, MD.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |   |  |                                      |   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Greater Balto Medical Center |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>BARTENDER |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Anne Arundel   |  | 13c. CITY OR TOWN<br>ANNAPOLIS  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                    |   | 13e. STREET AND NUMBER<br>308 CHESTER AVENUE |                                      |   |  |
| 14. FATHER'S NAME First Middle Last<br>ERNEST James SMITH   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>CATHERINE NMN BROWN   |  |   |   |  |                                      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No ***  |  | 16b. SOCIAL SECURITY NO.<br>216-18-3001   |  | 17. INFORMANT Address<br>Beatrice P. Smith 308 Chester Ave  |  |   |   |  |                                      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pulmonary sepsis<br>1419<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Carcinoma of tongue and pharynx with metastases<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>1992 |  |   |  |   |  |   |   |  |                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? Yes |  |                                      |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |                                      |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (At home, farm, street, factory,<br>OFFICE BUILDING, ETC.)                                 |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |                                      |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/26, 19 68, to 4/27, 19 68, that (I) (we) lost<br>saw the deceased alive on 4/27 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |   |  |                                      |   |  |
| 22b. SIGNATURE<br>John E. Adams   |  |   |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br>4/27/68                  |                                      |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>John E. Adams, M.D.  |  |   |  |   | 22e. ADDRESS<br>6701 N. Calvert Street   |   |   |  |                                      |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>5-1-1968   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PineLawn Mem.Pk   |  |   | 23d. LOCATION (City or Town) (County) (State)<br>Annapolis A.A. Md          |  |                                      |   |  |
| 24. FUNERAL DIRECTOR<br>C.E. Hicks, 111 Annapolis, Md   |  |   |  |   | 25a. REC'D BY REGISTRAR<br>DATE APR 30 1968  |   |   | 25b. REGISTRAR'S SIGNATURE<br>John E. Adams  |                                      |   |  |

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*[Handwritten signature]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05398

|  |  |   |                             |   |  |   |
|--|--|---|-----------------------------|---|--|---|
| 1. DECEASED NAME<br>(Type or print)<br><b>Helen</b>  |  | First<br><b>L.</b>  | Middle<br><b>Sommerlatt</b> | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>30</b> Year <b>1968</b>  |  | 2b. HOUR<br><b>12:15</b><br>a.m.  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>white</b>   |                             | 5. DATE OF BIRTH<br><b>August 28, 1886</b>  |  | 6. AGE (In years<br>last birthday)<br><b>81</b> YRS.  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore County</b> Md.   |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Spring Grove State Hospital</b> |                             | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>housewife</b>  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |
| 13a. USUAL RESIDENCE (Where deceased<br>lived, if institution: Residence before<br>admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |                             | 13c. CITY OR TOWN<br><b>2818 NorthWind Road</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>First <b>John</b> Middle <b>Wesley</b> Last <b>Knight</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Eliza</b> Middle <b>Ellen</b> Last <b>Fisher</b>                                 |                             |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no <input checked="" type="checkbox"/> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>219-03-8843</b>  |                             | 17. INFORMANT<br>Address<br><b>Records: Spring Grove State Hospital</b>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>4109<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Cardiovascular Ht. Dis.</b> 20 yrs<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerosis, Generalized, Senile.</b> 20 yrs. |  |   |                             |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>acute</b>                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4201   |  |   |                             |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                             | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |                             | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                       |                             | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>March 1, 1968</b> , to <b>April 30, 1968</b> , that (b) (we) last<br>saw the deceased alive on <b>April 30, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (c) (we) (did not) view the body after death.   |  |   |                             |   |  |   |
| 22b. SIGNATURE<br><b>Anthony J. Young, M.D.</b>  |  |   |                             | DEGREE ATTENDING<br>PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                |  | 22c. DATE SIGNED<br><b>May 1, 1968</b>  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>Anthony J. Young, M.D.</b>   |  |   |                             | 22e. ADDRESS<br><b>Spring Grove State Hospital<br/>Baltimore, Maryland 21228</b>  |  |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE<br><b>5/4/68</b>  |                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Prosperity Church Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pleasant Valley Pa.</b>                     |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Buck Inc. Baltimore, Maryland</b>  |  |   |                             | 25a. REC'D BY REGISTRAR<br>DATE <b>MAY 2 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 6 Film G399 1/15/68  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05399

|  |  |   |  |   |   |   |   |  |        |  |       |                                   |  |
|--|--|---|--|---|---|---|---|--|--------|--|-------|-----------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Mildred Irene Stanley</i>   |  |   | 2a. DATE OF DEATH<br>4 Month 7 Day 68 Year                   |   |   | 2b. HOUR<br>11:59 AM  |   |  |        |  |       |                                   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>Cau</i>   |  | 5. DATE OF BIRTH<br><i>3-26-18</i>  |   | 6. AGE (in years last birthday)<br><i>50</i> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.          |        | IF UNDER 14 HRS.   |       |                                   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Balto, Md.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.  |   |  |        |  |       |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore, Md.</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>G.B.M.C.</i> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Housewife</i> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                  |        |  |       |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>  |  | 13b. COUNTY<br><i>-</i>   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><i>3438 Keswick Rd.</i>  |        |  |       |                                   |  |
| 14. FATHER'S NAME First Middle Last<br><i>Franklin Unknown Snouffer</i>  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>SHifley</i> |   |   |   |   |  |        |  |       |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><i>no</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>unknown</i>  |  | 17. INFORMANT<br><i>Patient's chart</i> Address   |   |   |   |  |        |  |       |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><i>7341</i> IMMEDIATE CAUSE (a) <i>Perforated intra-abdominal viscus</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Systemic Lupus Erythematosus</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>6 years</i>  |  |   |  |   |   |   |   |  |        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>12-24 hours</i>   |       |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>456x</i>  |  |   |  |   |   |   |   |  |        |  |       |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?      |  |        |  |       |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                      |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                             |   |   |  |        |  |       |                                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                    |  |   | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |  | County |  | State |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/16</i> , 19 <i>68</i> , to <i>4/7</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4/7</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |   |  |        |  |       |                                   |  |
| 22b. SIGNATURE<br><i>Derek A Bruce</i>   |  |   |  |   |   |   |   |  |        | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |       | 22c. DATE SIGNED<br><i>4/7/68</i> |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>DEREK A. BRUCE.</i>   |  |   |  |   |   |   |   |  |        | 22e. ADDRESS<br><i>G. B. M. C.</i>   |       |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><i>4/10-68</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Garden of Faith</i>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore City Md</i> |  |        |  |       |                                   |  |
| 24. FUNERAL DIRECTOR<br><i>Frank H. Seitz</i>  |  |   |  | ADDRESS<br><i>874 W 36th St</i>   |   | 25a. REC'D BY REGISTRAR<br>DATE <i>APR 10 1968</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i> |        |  |       |                                   |  |



Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

|  |  |   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|---|--|--|--|---|--|
| MAYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |   |  |  |  |   |  |
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MAYLAND 21201   |  |   |  |   |  |   |  |  |  |   |  |
| 05398 CERTIFICATE OF DEATH 05400   |  |   |  |   |  |   |  |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br>Charles  |  | Middle<br>L.  |  | Last<br>Stauffer SR   |  | 2a. DATE OF DEATH<br>Month 04 Day 06 Year 68                         |  | 2b. HOUR<br>4:00  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>9-30-03   |  |   |  | 6. AGE (In years last birthday)<br>64 YRS.                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Baltimore   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore County Md.  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Balto. Co. Gen. Hosp. |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Retired.                             |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Sealed Co |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Randallstown   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  | 13e. STREET AND NUMBER<br>3526 Rolling Rd.                           |  |   |  |
| 14. FATHER'S NAME First Middle Last<br>Artie Stauffer  |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Ella Wilt.  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>No.   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                                     |  | 17. INFORMANT<br>Wm. Charles H. Stauffer SR Address 21397<br>3526 Rolling Rd  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>410.9 DUE TO, OR AS A CONSEQUENCE OF<br>(b) Atherosclerotic Cardiovascular Disease<br>4 yrs<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>4201 |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hrs           |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County   |  | State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/6, 1968, to 4/6, 1968, that (I) (we) last saw the deceased alive on 4/6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Arthur A. Serpick  |  |   |  | DEGREE  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br>4/6/68   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Arthur A Serpick   |  |   |  | 22e. ADDRESS<br>5601 old Court Rd   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>4/9/68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn  |  | 23d. LOCATION (City or Town)<br>Woodlawn, Md  |  | (County)   |  | (State)   |  |
| 24. FUNERAL DIRECTOR<br>Xoring Byers - 8725 Liberty Road   |  |   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE APR 11 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                          |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |                     |   |                        |  |   |   |                             |   |  |
|---|--|--|---|--|---------------------|---|------------------------|--|---|---|-----------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |                     |   |                        |  |   |   |                             |   |  |
| CERTIFICATE OF DEATH  |  |  |   |  |                     |   |                        |  |   |   |                             |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><b>WILLARD</b>   |  | Middle<br><b>E.</b> |   | Last<br><b>STEWART</b> |  | 20. DATE OF DEATH<br>Month <b>4</b> Day <b>18</b> Year <b>68</b>                                |   | 26. HOUR<br><b>1:30 A M</b> |   |  |
| 3. SEX<br><b>MALE</b>   |  |  | 4. RACE<br><b>NEGRO</b>   |  |                     | 5. DATE OF BIRTH<br><b>9/26/90</b>  |                        |  | 6. AGE (In years last birthday)<br><b>77</b> YRS.   |   |                             | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                        |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY,</b> Md.  |   |                             |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET. ADM. HOSPITAL</b> |  |                     | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>LABORER</b>   |                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CONSTRUCTION</b>  |   |                             |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  |                     | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |                             | 13e. STREET AND NUMBER<br><b>712 N. Arlington Street</b>    |  |
| 14. FATHER'S NAME<br>First <b>John</b> Middle <b>Steward</b> Last <b>Steward</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>ANNIE</b> Middle <b>MASON</b> Last <b>MASON</b>                      |  |                     |   |                        |  |   |   |                             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>YES</b> (If yes give war or dates of service)<br><b>WW I</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>215 10 02 74</b>   |  |                     | 17. INFORMANT<br>Address<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>   |                        |  |   |   |                             |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b>   |  |  |   |  |                     |   |                        |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>RECENT</b> |                             |   |  |
| 4120<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>4428</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>THROMBOSIS, RIGHT VETERAL ARTERY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE</b>   |  |  |   |  |                     |   |                        |  |   |   |                             |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>ARTERIOSCLEROSIS, MARKED GENERALIZED AND CEREBRAL, BENIGN PROSTATIC HYPERTROPHY, CHRONIC CYSTITIS, BURNS (THERMAL) POSTERIOR THIGHS, LEGS, PERINEUM AND PENIS,</b>  |  |  |   |  |                     |   |                        |  |   |   |                             |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b>              |   |                             |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |                     | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                        |  |   |   |                             |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |  |                     | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |                        |  |   |   |                             |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>2/5/68</b> , 19____, to <b>4/18/68</b> , 19____, that (X) (we) last saw the deceased alive on <b>4/18/68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. |  |  |   |  |                     |   |                        |  |   |   |                             |   |  |
| 22b. SIGNATURE<br><b>ERISHNA V. S. BAO, M. D.</b>   |  |  |   |  |                     |   |                        |  | 22c. DATE SIGNED<br><b>4/18/68</b>  |   |                             |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>ERISHNA V. S. BAO, M. D.</b>   |  |  |   |  |                     |   |                        |  | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |   |                             |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>4/23/68</b>   |  |                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   |                        |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                     |   |                             |   |  |
| 24. FUNERAL DIRECTOR<br><b>ROLAND BROWN FUNERAL</b>   |  |  |   |  |                     | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 23 1968</b>  |                        |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |                             |   |  |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

05400

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05402

|   |                      |   |  |   |   |   |  |
|---|----------------------|---|--|---|---|---|--|
| 1. DECEASED-NAME (Type or Print) <b>WILLIAM</b>   |                      | First Middle Last <b>F. SWIST</b>   |  | 2a. DATE KNOWN <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> OF ESTI-DEATH MATED <input type="checkbox"/> <b>April 5, 1968</b>   |   | 2b. HOUR <b>9:50<sup>a</sup></b>  |  |
| 3. SEX <b>Male</b>  | 4. RACE <b>White</b> | 5. DATE OF BIRTH <b>10-9-1915</b>   | 6. AGE (In years last birthday) <b>52</b> YRS. | IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD Month <b>April</b> Day <b>5</b> Year <b>1968</b>         |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |   | 9. COUNTY OF DEATH <b>Baltimore</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH <b>Catonsville</b>  |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holiday Inn</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Tech. Engineer</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Mass.</b>  |                      | 13b. COUNTY <b>Fall River</b>   |  | 13c. CITY OR TOWN <b>Fall River</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER <b>85 Chace Street</b>   |                      | 14. FATHER'S NAME First Middle Last <b>William J. Swist</b>                                     |  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary A. Cartin</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)                |  |
| 16b. SOCIAL SECURITY NO.  |                      | 17. INFORMANT ADDRESS <b>Fall River, Donnelly Funeral Home, 1173 S. Main St. Mass.</b>          |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4129</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221 Acute Ethylism</b>  |                      |   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>                                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |                      | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                    |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an <b>Autopsy</b> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                      |   |  |   |   |   |  |
| ACTUAL SIGNATURE <b>Ronald N. Kornblum</b>  |                      | M.D. <b>Ronald N. Kornblum, M.D.</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |   | 22b. DATE SIGNED <b>4-5-68</b>  |  |
| EXAMINER'S NAME (Type)  |                      | ADDRESS   |  | 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |   | 23b. DATE <b>4-9-1968</b>   |  |
| 24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>  |                      | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick Cemetery</b>                                  |  | 23d. LOCATION (City or Town) (County) (State) <b>Fall River, Massachusetts</b>  |   | 25a. REC'D BY REGISTRAR <b>APR 10 1968</b>  |  |
|   |                      |   |  | 25b. REGISTRAR'S SIGNATURE <b>M. Santos Judge</b>   |   |   |  |

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|--|--|---------------|--|
| 1. Name of the person or organization  |  | 2. Address    |  |
| 3. City                                |  | 4. State      |  |
| 5. Zip                                 |  | 6. Telephone  |  |
| 7. Date                                |  | 8. Signature  |  |
| 9. Title                               |  | 10. Remarks   |  |
| 11. Name of the person or organization |  | 12. Address   |  |
| 13. City                               |  | 14. State     |  |
| 15. Zip                                |  | 16. Telephone |  |
| 17. Date                               |  | 18. Signature |  |
| 19. Title                              |  | 20. Remarks   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

MEDICAL CERTIFICATION

|  |  |  |   |   |  |   |                                   |  |
|--|--|--|---|---|--|---|-----------------------------------|--|
| 05401  |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |   |   |  | 05403   |                                   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Stanley</b>   |  |  | First   | Middle  | Last   | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>17</b> Year <b>1968</b>                              |                                   | 2b. HOUR<br><b>6:25</b> p. M                                     |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>negro</b>  |   | 5. DATE OF BIRTH<br><b>12-25-1887</b>   |  | 6. AGE (In years last birthday)<br><b>80</b> YRS.   |                                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 14 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia, US</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore County</b> Md.   |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Spring Grove State Hospital</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Porter</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER<br><b>905 W. Saratoga St. Baltimore</b>   |
| 14. FATHER'S NAME<br>First <b>John</b> Middle <b>Wesley</b> Last <b>Sykes</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Mary</b> Middle Last |   |  |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>Unknown</b>   |   | 17. INFORMANT<br><b>Hospital Record.</b>  |  | Address   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Generalized Atherosclerosis</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Left Hemiplegia due to Cerebral Thrombosis</b> |  |  |   |   |  |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |
| 19a. DATE OF OPERATION<br><b>no</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |                                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                       |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>February 18, 1964</b> , to <b>April 17, 1968</b> , that (I) (we) last saw the deceased alive on <b>April 17, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |                                   |  |
| 22b. SIGNATURE<br><b>Raul L. Machado</b>   |  | 11669  |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                              |  | 22c. DATE SIGNED<br><b>4/17/1968</b>  |                                   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS<br><b>Spring Grove State Hospital</b>   |   |   |  |   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><b>4-22-68</b>  |   | 23c. NAME OF CEMETERY OR CREMATOR<br><b>Baltimore Cat</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>                           |                                   |  |
| 24. FUNERAL DIRECTOR<br><b>Ebony Wilson</b>  |  | ADDRESS<br><b>1130 Brantly on Belmont</b>  |   | 25a. REGD. BY REGISTRAR<br>DATE <b>APR 19 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James Judge</b>  |                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 05402   |  |  |  |  |   |  |  |  |  | 05404  |  |                             |  |  |  |   |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|--|--|-----------------------------|--|--|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |  |  | CERTIFICATE OF DEATH   |  |                             |  |  |  |   |  |  |  |  |
| 1. DECEASED-NAME (Type or print) <b>MADELINE E. TATE</b>  |  |  |  |  | First Middle Last   |  |  |  |  | 2a. DATE OF DEATH <b>April 25, 1968</b>  |  |                             |  |  | 2b. HOUR <b>M</b>  |   |  |  |  |  |
| 3. SEX <b>Female</b>  |  |  | 4. RACE <b>White</b>   |  |   | 5. DATE OF BIRTH <b>July 20, 1901</b>  |  |  | 6. AGE (In years last birthday) <b>66</b> YRS.                           |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  | IF UNDER 24 HRS. HOURS MIN.                                  |   |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                   |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH <b>Baltimore</b> Md.                                  |  |  |                             |  |  |  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Catonsville</b>  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Shady Nook Nursing Home</b>                     |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b> |  |                             |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                            |   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  |  |  |  | 13b. COUNTY <b>Baltimore</b>  |  |  |  |  | 13c. CITY OR TOWN <b>Arbutus</b>   |  |                             | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER <b>1320 Stevens Ave. 21227</b> |  |  |  |  |
| 14. FATHER'S NAME First Middle Last <b>William Funk</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Roeder</b>   |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>215-01-3888</b>   |  |  |  |  | 17. INFORMANT Address <b>Mrs. Sarah Till, 2023 Annapolis Rd. 21230</b>                                   |  |                             |  |  |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1829</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Uterus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |   |  |  |  |  |  |  |                             |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 yrs</b> |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>174 x</b>  |  |  |  |  |   |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |  |  |                             |  |  |  |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>                  |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-19</b> , 19 <b>68</b> , to <b>April 25</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-19</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE <b>Earl Pass M.D.</b> DEGREE   |  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED <b>4-25-68</b>  |  |                             |  |  |  |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Dr. Earl Pass</b>   |  |  |  |  | 22e. ADDRESS <b>4001 Wilkens Ave., Balto., Md.</b>  |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMAINS (Specify)   |  |  | 23b. DATE <b>4-29-1968</b>   |  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>   |  |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b> |  |  |                             |  |  |  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE <b>APR 29 1968</b>   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |                             |  |  |  |   |  |  |  |  |

MEDICAL CERTIFICATION

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FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |                  |  |  |  |  |  |  |  |   |  |  |  |  |  |
|--|--|------------------|--|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME (Type or Print) <u>H. Jackson Taughinbaugh Jr.</u>  |  |                  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>April</u> Day <u>29</u> Year <u>1968</u> |  | 2b. HOUR <u>8:15</u> M   |  |  |  |
| 3. SEX <u>M</u>  |  | 4. RACE <u>W</u> |  | 5. DATE OF BIRTH <u>4-17-1950</u>  |  | 6. AGE (in years last birthday) <u>18</u> YRS. |  | IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u>  |  | IF UNDER 24 HRS. HOURS <u>  </u> MIN <u>  </u>  |  | 2c. DATE PRONOUNCED DEAD Month <u>April</u> Day <u>29</u> Year <u>1968</u>             |  | 2d. HOUR <u>8:15</u> M                                     |  |
| 7a. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. COUNTY OF DEATH <u>Balto.</u>   |  |  |  |
| 1d. CITY OR TOWN OF DEATH <u>Towson</u>  |  |                  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>St. Joseph's Hosp.</u> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Student</u>   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>High School</u>                                   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>   |  |                  |  | 13b. COUNTY <u>Balto. - Freeland</u>   |  |  |  | 13c. CITY OR TOWN <u>  </u>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  | 13e. STREET AND NUMBER <u>Eagle Mill Rd.</u>   |  |  |  |
| 14. FATHER'S NAME First <u>H. Jackson</u> Middle <u>Taughinbaugh</u> Last <u>  </u>  |  |                  |  | 15. MOTHER'S MAIDEN NAME First <u>Sarah</u> Middle <u>Kathryn</u> Last <u>Provost</u>                  |  |  |  |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>  |  |                  |  | 16b. SOCIAL SECURITY NO. <u>213-50-4767</u>  |  |  |  | 17. INFORMANT ADDRESS <u>H.S. Taughinbaugh, Freeland, Md</u>   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple Crushing Injuries</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>of Chest and Head.</u><br>(b) <u>Multiple Fractures of Left Femur</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>  </u><br>(c) <u>  </u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>  </u> |  |                  |  |  |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 Hrs</u> |  |
| 19a. DATE OF OPERATION <u>8129</u>   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>  </u>  |  |  |  | 2d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>  </u>  |  |                  |  | 21b. TIME OF INJURY Month, Day, Year <u>9:30 A.M. April 28, 1968</u>                                   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Probably in Head-on Crash with no other</u>                           |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Highway</u>            |  |  |  | 21f. LOCATION Street or R.F.D. No. <u>W. Kersville Rd.</u> City or Town <u>North Parkton</u> County <u>Freeland</u>                                      |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |                  |  |  |  |  |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>   |  |                  |  | EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>   |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                    |  |  |  |
|  |  |                  |  |  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  | 22b. DATE SIGNED <u>4/29/68</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |                  |  | 23b. DATE <u>5-1-68</u>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lion Cemetery</u>  |  |   |  | 23d. LOCATION (City or Town) <u>Freeland</u> (County) <u>Balto.</u> (State) <u>Md.</u> |  |  |  |
| 24. FUNERAL DIRECTOR <u>Jacob Hartenstein</u>  |  |                  |  | ADDRESS <u>New Freedom, Pa.</u>  |  |  |  | 25a. REC'D BY REGISTRAR <u>  </u> DATE <u>MAY 2 1968</u>   |  |   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |  |  |

05505

05505



April 21 1888  
April 21 1888

Multiple Overlapping  
of Chest and  
Multiple Fractures of Ribs

1st rib - 1st dorsal spine  
2nd rib - 2nd dorsal spine

Multiple Fractures of Ribs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |
|---|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle   |  | Last   |  | 2a. DATE OF DEATH  |  |                                   |  | 2b. HOUR                                     |  |
| Baby Girl Mary Christine Tayag  |  |  |  |  |  |  |  | 4 Month 27 Day 68 Year   |  |                                   |  | 6:04 a.m.                                    |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |  |  | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS.                             |  |
| Female  |  | Cau  |  | 4/26/68  |  |  |  | 0 YRS.   |  | MONTHS 1 DAYS                     |  | HOURS MIN                                    |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |                                   |  |  |  |
| Maryland  |  | U.S.A.   |  |  |  | Baltimore Md.  |  |  |  |                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| Towson  |  | Greater Balto. Medical Center  |  |  |  | None   |  |  |  |                                   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |                                   |  |  |  |
| Maryland  |  | Balto  |  | Towson   |  |  |  | 8216 Thornton Rd.  |  |                                   |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |                                   |  |  |  |
| First Middle Last   |  | First Middle Last  |  |  |  |  |  |  |  |                                   |  |  |  |
| Balbino Z. Tayag  |  | Diadema Simon  |  |  |  |  |  |  |  |                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address  |  |  |  |                                   |  |  |  |
| No  |  | None   |  | Dr. Balbino Z. Tayag   |  | 8216 Thornton Rd.  |  |  |  |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>  |  |  |  |  |  |  |  |  |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 7769 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypoxia</u>  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Maternal shock</u>   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |
| 7730  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |  |                                   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |                                   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |                                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 26, 1968</u> , to <u>April 27, 1968</u> , that (I) (we) lost the deceased on <u>April 27, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |                                   |  |  |  |
| 22b. SIGNATURE <u>John E. Adams</u>   |  |  |  |  |  |  |  |  |  |                                   |  | 22c. DATE SIGNED                             |  |
| DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |                                   |  | 4/27/68                                      |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |                                   |  |  |  |
| John E. Adams, M.D.   |  |  |  | 6701 N. Charles Street   |  |  |  |  |  |                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  | 23d. LOCATION (City or Town) (County) (State)                            |  |                                   |  |  |  |
| Burial  |  | 4/29/68  |  | Dulaney Valley Cemetery  |  |  |  | Cockeysville, Md. Balto.   |  |                                   |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                                   |  |  |  |
| Wm. Cook-Brooks Towson 1050 York Rd. 21204  |  |  |  | DATE MAY 3 1968  |  | <u>Charles Judge</u>   |  |  |  |                                   |  |  |  |

81-08783

332



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |   |        |  |  |  |                              |   |                                   |
|--|--|---|--------|--|--|--|------------------------------|---|-----------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <i>Melvin</i>  |  | First <i>H.</i>   | Middle | Last <i>Teufel</i>   | 2a. DATE OF DEATH<br>Month <i>April</i> Day <i>28</i> Year <i>1968</i> |  | 2b. HOUR<br><i>1:20</i> P.M. |   |                                   |
| 3. SEX<br><i>M</i>   |  | 4. RACE<br><i>W</i>   |        | 5. DATE OF BIRTH<br><i>2/13/05</i>   |  | 6. AGE (In years lost birthday)<br><i>63</i> YRS.                                    |                              | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                                 | IF UNDER 24 HRS.<br>HOURS<br>MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><i>md.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.   |                              |   |                                   |
| 10. CITY OR TOWN OF DEATH<br><i>Catoxville</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Summit Nursing Hm.</i> |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Retired</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                              |   |                                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>md.</i>  |  | 13b. COUNTY<br><i>Balto.</i>  |        | 13c. CITY OR TOWN<br><i>Catoxville</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                              | 13e. STREET AND NUMBER<br><i>5713 Edmondson Ave.</i>              |                                   |
| 14. FATHER'S NAME<br>First <i>John</i> Middle <i>Teufel</i> Last <i>Teufel</i>   |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Pauline</i> Middle <i>Mitchell</i> Last <i>Mitchell</i>              |        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)                                      |  | 16b. SOCIAL SECURITY NO.<br><i>705-05-2540</i>                                       |                              | 17. INFORMANT<br><i>Mrs. Marie M. Teufel, 5713 Edmondson Ave.</i> |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac failure</i><br><i>1621</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Myocardial Degeneration</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Carcinoma of Lung</i> |  |   |        |  |  |  |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><i>163X</i><br><i>Cirrhosis of Liver</i>   |  |   |        |  |  |  |                              |   |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |                              |   |                                   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |                              |   |                                   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |        | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |                              |   |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June 1966</i> , to <i>28 April 1968</i> , that (I) (we) last saw the deceased alive on <i>28 April 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |        |  |  |  |                              |   |                                   |
| 22b. SIGNATURE<br><i>William J. Bryson</i>   |  | 22c. PHYSICIAN'S NAME (Type)<br><i>Dr. William W. Bryson</i>  |        | 22d. ADDRESS<br><i>4605 Edmondson Ave., Balto., Md.</i>  |  | 22e. DATE SIGNED<br><i>30 April 68</i>   |                              |   |                                   |
| 23a. BURIAL, CREMATION, RESUMPTION (Specify)<br><i>BURIAL</i>  |  | 23b. DATE<br><i>5-1-1968</i>  |        | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Druid Ridge Cemetery</i>  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Pikesville, Maryland</i>         |                              |   |                                   |
| 24. FUNERAL DIRECTOR<br><i>Howard H. Hubbard, 4107 Wilkens Ave. 21229</i>  |  | 25a. REC'D BY REGISTRAR<br>DATE <i>MAY 01 1968</i>  |        | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |  |                              |   |                                   |

MEDICAL CERTIFICATION

10101

STATE OF TEXAS

10101

Handwritten notes and signatures on the right margin, including a large signature at the top and several smaller ones below.

Main body of the document containing multiple lines of faint, mostly illegible text, possibly representing a list or a series of entries.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

| <div style="display: flex; justify-content: space-between;"> <span>05406</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>05406</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br/> <b>CERTIFICATE OF DEATH</b> </div>                            |  |  |  |  |  |   |  |  |   |  |  |  |  |   |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><b>Bertha</b>   |  |  | Middle<br><b>Teves</b>  |  |  | Last  |  |  | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>23</b> Year <b>1968</b> |  |   | 2b. HOUR<br><b>7:55</b> p. <b>55</b> M |  |
| 3. SEX<br><b>female</b>   |  |  | 4. RACE<br><b>white</b>  |  |  | 5. DATE OF BIRTH<br><b>May 24, 1877</b>   |  |  | 6. AGE (In years<br>last birthday)<br><b>90</b> YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                       |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b> |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Va.</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  | Md.  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>SPRING GROVE STATE HOSP.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>housewife</b>  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>Balto.</b>   |  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>215 S. Augusta Ave.</b>                   |  |   |  |  |
| 14. FATHER'S NAME First<br><b>Unknown to records</b>  |  |  | Middle<br><b>Unknown to records</b>  |  |  | Last<br><b>Unknown to records</b>   |  |  | 15. MOTHER'S MAIDEN NAME First<br><b>Unknown to records</b>                                     |  |  | Middle<br><b>Unknown to records</b>                                    |  |   | Last<br><b>Unknown to records</b>      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>no</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>212-07-5200</b>                            |  |  | 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>  |  |  | Address   |  |  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Right carotid artery thrombosis</b>   |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5 days</b>       |  |   |  |  |
| Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. <b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |  |  |   |  |  |   |  |  | years  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221</b>   |  |  |  |  |  |   |  |  |   |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                    |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 17, 1967</b> , to <b>April 23, 1968</b> , that (I) (we) last<br>saw the deceased alive on <b>April 23, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |   |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Dr. Diomidis L. Pirovolidis</b>  |  |  | DEGREE   |  |  | ATTENDING<br>PHYS. <input checked="" type="checkbox"/>  |  |  | MED.<br>DIRECTOR <input type="checkbox"/>   |  |  | STAFF<br>PHYS. <input type="checkbox"/>                                |  |   | 22c. DATE SIGNED<br><b>4-23-68</b>     |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>Diomidis Pirovolidis, M.D.</b>  |  |  | 22e. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>                                   |  |  |   |  |  |   |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>4/29/68</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LORRAINE PK. Cer</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. Md.</b>                              |  |  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>E S MacNabb</b>  |  |  | ADDRESS<br><b>301 Frederick Rd<br/>Catonsville Md.</b>   |  |  | 25a. REC'D BY REGISTRAR<br><b>APR 30 1968</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |  |   |  |  |

MEDICAL CERTIFICATION

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1005. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |         |                  |  |                 |      |  |      |                          |  |  |           |
|---|---------|------------------|--|-----------------|------|--|------|--------------------------|--|--|-----------|
| 1. DECEASED-NAME<br>(Type or Print)   |         |                  | First Middle Last  |                 |      | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED   |      |                          | 2b. HOUR   |  |           |
| F. Lee Thomas   |         |                  |  |                 |      | 4-29-68  |      |                          | 2:30 P.M.  |  |           |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR |      | IF UNDER 24 HRS.   |      | 2c. DATE PRONOUNCED DEAD |  |  | 2d. HOUR  |
| M.  | W.      | 4/27/1898        | 70 YRS.  | MONTHS          | DAYS | HOURS  | MIN. | Month 4 Day 29 Year 1968 |  |  | 4:30 P.M. |
| 7a. BIRTHPLACE (State or foreign country)   |         |                  | 7b. CITIZEN OF WHAT COUNTRY?   |                 |      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |                          | 9. COUNTY OF DEATH   |  |           |
| Md.   |         |                  | U.S.A.   |                 |      |  |      |                          | Baltimore Md.  |  |           |
| 10. CITY OR TOWN OF DEATH   |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                 |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |      |                          | 12b. KIND OF BUSINESS OR INDUSTRY  |  |           |
| Middle River, Md.   |         |                  | 3 A. Oak Grove Dr. Balto.  |                 |      | Ret. Balto. Transit Co.  |      |                          |  |  |           |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                  | 13b. COUNTY  |                 |      | 13c. CITY OR TOWN  |      |                          | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |           |
| Md.   |         |                  | Balto.   |                 |      | Balto.   |      |                          | 3 A. Oak Grove Dr.   |  |           |
| 14. FATHER'S NAME   |         |                  | 15. MOTHER'S MAIDEN NAME   |                 |      |  |      |                          |  |  |           |
| First Middle Last   |         |                  | First Middle Last  |                 |      |  |      |                          |  |  |           |
| William Thomas  |         |                  | Emma V. Staylor  |                 |      |  |      |                          |  |  |           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |                  | 16b. SOCIAL SECURITY NO.   |                 |      | 17. INFORMANT  |      |                          | ADDRESS  |  |           |
| no  |         |                  | 213-10-2790A   |                 |      | Christine Thomas   |      |                          | Same   |  |           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4129 H-S-C-V Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |                  |  |                 |      |  |      |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br>4221  |         |                  |  |                 |      |  |      |                          |  |  |           |
| 19a. DATE OF OPERATION  |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |                 |      | 20. AUTOPSY?   |      |                          |  |  |           |
|   |         |                  | None   |                 |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |      |                          |  |  |           |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M.                    |                 |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |      |                          |  |  |           |
|   |         |                  | 19   |                 |      |  |      |                          |  |  |           |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |         |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                 |      | 21f. LOCATION Street or R.F.D. No.   |      |                          | City or Town County State  |  |           |
|   |         |                  |  |                 |      |  |      |                          |  |  |           |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                  |  |                 |      |  |      |                          |  |  |           |
| ACTUAL SIGNATURE Melvin B Davis   |         |                  |  |                 |      | CHIEF MEDICAL EXAMINER   |      |                          | 22b. DATE SIGNED 4/29/68   |  |           |
| EXAMINER'S NAME (Type) Melvin B Davis MD  |         |                  |  |                 |      | ASSISTANT MEDICAL EXAMINER   |      |                          | DEPUTY MEDICAL EXAMINER  |  |           |
|   |         |                  |  |                 |      | ADDRESS (Street, city, town, or county)  |      |                          | 6800 MORNINGTON RD, 21222  |  |           |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |                  | 23b. DATE  |                 |      | 23c. NAME OF CEMETERY OR CREMATORY   |      |                          | 23d. LOCATION (City or Town) (County) (State)  |  |           |
| Burial  |         |                  | 5/2/68   |                 |      | Woodlawn Cem.  |      |                          | Balto. Md.   |  |           |
| 24. FUNERAL DIRECTOR  |         |                  |  |                 |      | ADDRESS  |      |                          | 25a. REC'D BY REGISTRAR  |  |           |
| Leonard J Ruck Inc, Baltimore, Maryland   |         |                  |  |                 |      |  |      |                          | 25b. REGISTRAR'S SIGNATURE Charles Judge   |  |           |
|   |         |                  |  |                 |      | DATE APR 29 1968   |      |                          |  |  |           |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

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MAY 1 1968  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH  
05410

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(Type or print)<br><b>ERNEST THOMPSON</b>   |  | First Middle Last   |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>APRIL 20 1968</b>   |  | 2b. HOUR<br><b>5:00 PM</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Colored</b>   |  | 5. DATE OF BIRTH<br><b>11/26/12</b>   |  | 6. AGE (In years last birthday)<br><b>55</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore, Md.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Fort Howard</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Veterans Administration Hosp. Burner</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Steel</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>656 Bartlett Avenue</b>  |  | 14. FATHER'S NAME<br>First Middle Last<br><b>Samuel Thompson</b>  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Agnes Henson</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW II</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-03-5170</b>  |  | 17. INFORMANT<br><b>Clin. Records, VAH, Fort Howard, Maryland</b>   |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHIOPNEUMONIA CONFLUENT BILATERAL</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PULMONARY ABSCESS, RIGHT UPPER LOBE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>POST OPERATIVE CARCINOMA OF FLOOR OF MOUTH</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>143X</b>         |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b>           |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 15, 1967</b> , to <b>April 20, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 20, 1968</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Mario J. Quiros</b>  |  | DEGREE<br><b>M. D.</b>  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>4 21 68</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>MARIO J. QUIROS, M. D.</b>   |  | 22e. ADDRESS<br><b>VAH, FORT HOWARD, MD.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/25/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                  |  |
| 24. FUNERAL DIRECTOR<br><b>MARSHALL JONES FUNERAL HOME</b>  |  | ADDRESS<br><b>1735 Harford Ave.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 22 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. J...</b>   |  |

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• *Journal of the American Medical Association*, 2000; 283: 2639-2644

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• Question • Answer • Comment

Figure 1

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— *Journal of the American Medical Association*

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |                              |  |   |      |   |      |  |   |
|--|---------|------------------------------|--|---|------|---|------|--|---|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |                              |  |   |      |   |      |  |   |
| 1. DECEASED-NAME (Type or Print)   |         |                              | First Middle Last  |   |      | 2a. DATE KNOWN OF DEATH   |      |  | 2b. HOUR                                      |
| MARY KIMBERLY Glenn TIEPERMAN  |         |                              |  |   |      | Month Day Year  |      |  | 11:20   |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR   |      | IF UNDER 24 HRS.  |      | 2c. DATE PRONOUNCED DEAD   |   |
| Female   | White   | Jan. 29, 1968                | YRS. 4   | MONTHS  | DAYS | HOURS   | MIN. | Month Day Year   | 11:20   |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. COUNTY OF DEATH  |      |  |   |
| Maryland   |         | U.S.A.                       |  |   |      | Balto.  |      |  |   |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |      |  | 12b. KIND OF BUSINESS OR INDUSTRY             |
| Balto.   |         |                              | St. Joseph Hospital  |   |      |   |      |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                              | 13b. COUNTY  |   |      | 13c. CITY OR TOWN   |      | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER                        |
| Md.  |         |                              | Balto.   |   |      | Balto.  |      |  | Apt. C  |
| 14. FATHER'S NAME First Middle Last  |         |                              | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |   |      |   |      |  |   |
| Richard Glenn Tieperman  |         |                              | Mary Beverly Rhodes  |   |      |   |      |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                              | 16b. SOCIAL SECURITY NO.   |   |      | 17. INFORMANT ADDRESS   |      |  |   |
| No   |         |                              | None   |   |      | Mr Richard G Tieperman Same   |      |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Interstitial pneumonia (SDII)</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |         |                              |  |   |      |   |      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |         |                              |  |   |      |   |      |  |   |
| 19a. DATE OF OPERATION   |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |   |      | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |      |  |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                              | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.                          |   |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |      |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   |      | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |      |  |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |   |      |   |      |  |   |
| ACTUAL SIGNATURE   |         |                              | M.D.   |   |      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |      |  | 22b. DATE SIGNED                              |
| EXAMINER'S NAME (Type)   |         |                              |  |   |      | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                          |      |  | April 20, 1968                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         |                              | 23b. DATE  |   |      | 23c. NAME OF CEMETERY OR CREMATORY  |      |  | 23d. LOCATION (City or Town) (County) (State) |
| Burial   |         |                              | 4/22/68  |   |      | Moreland Memorial Pk  |      |  | Baltimore, Maryland                           |
| 24. FUNERAL DIRECTOR   |         |                              | ADDRESS  |   |      | 25a. REC'D BY REGISTRAR   |      |  | 25b. REGISTRAR'S SIGNATURE                    |
| Leonard J Ruck Inc   |         |                              | Baltimore, Maryland  |   |      | APR 22 1968   |      |  | Charles Judge                                 |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

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|  |  |   |        |   |                                     |   |          |   |
|--|--|---|--------|---|-------------------------------------|---|----------|---|
| 1. DECEASED-NAME<br>(Type or print)  |  | First   | Middle | Last  | 2a. DATE OF DEATH<br>Month Day Year |   | 2b. HOUR |   |
| ALICE  |  |   |        | TOLSON  | April 6, 1968                       |   | 2:30pm   |   |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |        | 5. DATE OF BIRTH<br>December 16, 1869   |                                     | 6. AGE (In years last birthday)<br>98 YRS.  |          | IF UNDER 1 YEAR<br>MONTHS DAYS                  |
| 7a. BIRTHPLACE (State or foreign country)<br>OHIO  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. COUNTY OF DEATH<br>BALTIMORE   |          | Md.   |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>ST. JOSEPH HOSPITAL |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                     | 12b. KIND OF BUSINESS OR INDUSTRY   |          |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>BALTIMORE   |  | 13b. COUNTY<br>BALTIMORE  |        | 13c. CITY OR TOWN<br>TOWSON   |                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          | 13e. STREET AND NUMBER<br>103 LINDEN TERRACE #4 |
| 14. FATHER'S NAME  |  | First   | Middle | Last  | 15. MOTHER'S MAIDEN NAME            |   | First    | Middle Last                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes (do, or unknown) <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  | 16b. SOCIAL SECURITY NO.<br>None  |        | 17. INFORMANT<br>Family records   |                                     | Address   |          |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary infarction, multiple</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pulmonary thromboembolism, multiple</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>465 X</u> |  |   |        |   |                                     |   |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>A dynamic ileus. Acute ulcerative colitis</u>  |  |   |        |   |                                     |   |          |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |          |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                     |   |          |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                        |        | 21f. LOCATION   |                                     | Street or R.F.D. No.  |          | City or Town County State                       |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 27</u> , 19 <u>68</u> , to <u>April 6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>April 6</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |        |   |                                     |   |          |   |
| 22b. SIGNATURE<br><u>Reynaldo Orjuela-Gomez, M.D.</u>  |  | DEGREE  |        | ATTENDING PHYS.<br><input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |                                     | 22c. DATE SIGNED<br>April 6, 1968   |          |   |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS  |        | 7620 York Road, Towson 4, Maryland  |                                     |   |          |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>April 18, 1968   |        | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial Park  |                                     | 23d. LOCATION (City or Town) (County) (State)<br>Parkville, Maryland                            |          |   |
| 24. FUNERAL DIRECTOR<br><u>John Burns Sons, Towson, Md.</u>  |  | ADDRESS   |        | 25a. REC'D BY REGISTRAR<br>DATE APR 10 1968   |                                     | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |          |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |   |  |                                |
|--|--|--|--|--|--|---|--|---|--|--------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |   |  |                                |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |   |  |                                |
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br>JOSEPH  |  | Middle<br>FRANK  |  | Last<br>TRUITT ( Trutt )  |  | 2a. DATE OF DEATH<br>Month 4 Day 16 Year 68   |  | 2b. HOUR<br>6:05AM             |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>1/7/93   |  | 6. AGE (In years last birthday)<br>75 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                |  | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE COUNTY  |  | Md.   |  |                                |
| 10. CITY OR TOWN OF DEATH<br>FORT HOWARD   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>VET. ADM. HOSPITAL |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>LABORER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. GOVERNMENT  |  |   |  |                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>1706 Crystal Avenue |  |                                |
| 14. FATHER'S NAME<br>First Joseph Middle Truitt Last   |  | 15. MOTHER'S MAIDEN NAME<br>First Antoinette Middle Small Last                                     |  |  |  |   |  |   |  |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown Yes  |  | 16b. SOCIAL SECURITY NO.<br>WW I 216 16 31 28  |  | 17. INFORMANT Mrs WM. F. Kammerer 4120 Parkside CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.   |  |   |  |   |  |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4129 ACUTE PULMONARY EDEMA<br>DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF COLON AND DUODENAL BULB<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HOURS |  |  |  |  |  |   |  |   |  |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>DIABETES MELLITUS. CHRONIC BRAIN SYNDROME. OLD PULMONARY TUBERCULOSIS  |  |  |  |  |  |   |  |   |  |                                |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>YES                     |  |   |  |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |   |  |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                       |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State  |  |   |  |   |  |                                |
| 22a. I certify that (X) (this hospital) attended the deceased from 2/6/68, 19, to 4/16/68, 19, that (X) (we) lost<br>saw the deceased alive on 4/16/68, 19, and that in (our) opinion death occurred on the date and hour and from the<br>causes stated above (X) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |   |  |                                |
| 22b. SIGNATURE<br>Rodolfo Miro   |  | DEGREE<br>RODOLFO MIRO, M. D.  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>4/16/68   |  |   |  |                                |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS<br>VAH FORT HOWARD, MARYLAND  |  |  |  |   |  |   |  |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  | 23b. DATE<br>April 19,   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE NATIONAL   |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MARYLAND                            |  |   |  |                                |
| 24. FUNERAL DIRECTOR   |  | ADDRESS<br>H. SANDERS & SONS FUNERAL DIRECTORS   |  | 25a. REC'D BY REGISTRAR<br>DATE  |  | 25b. REGISTRAR'S SIGNATURE<br>Jorge   |  |   |  |                                |
|  |  | NORTH AVE. & BROADWAY  |  | BALTIMORE, MD.   |  |   |  |   |  |                                |

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1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05412

CERTIFICATE OF DEATH

05414

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>544 Park Avenue</u>   |   | d. STREET ADDRESS<br><u>544 Park Avenue</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Elmer</u> Middle <u>R.</u> Last <u>Tucker</u>  |   | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>16</u> Year <u>1968</u>   |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>November 1, 1883</u>            |
| 9. AGE (In years last birthday) yrs.<br><u>84</u>  |   | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  | 11. IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Architect-retired</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Building Trade</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Jacob Ruth Tucker</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Sarah Elizabeth Peregrory</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO.<br><u>216-20-7334</u>   |  |
| 17. INFORMANT<br><u>Mina S. Tucker</u>   |   | Address<br><u>544 Park Ave., Towson, Md.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4109 Coronary Thrombosis</u><br>DUE TO (b) <u>Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>  </u>          |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 10, 1960</u> to <u>April 16, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 16, 1968</u> , and that death occurred at <u>6:30 P.</u> M. from causes and on the date stated above.   |   |   |  |
| 22a. SIGNATURE<br><u>Laurence C. Post</u>  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             | 22b. DATE SIGNED<br><u>4/17/68</u>                     |
| 22c. PHYSICIAN'S NAME (Type)<br><u>LAURENCE C. POST</u>  |   | 22d. ADDRESS<br><u>6805 York Rd - Baltimore 21212 Md</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>April 19, 1968</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Baltimore Cemetery</u>   |  |
| 24. FUNERAL DIRECTOR<br><u>John Burns' Sons, Towson, Maryland</u>  |   | 25a. REC'D BY REGISTRAR<br><u>APR 19 1968</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   | 25c. ADDRESS<br><u>  </u>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MIDDLE  |  |                             |   |   |  |   |   |  |   |  |   |  |
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| 05413   |  |                             |   |   |  |   |   |  |   |  |   |  |
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                             |   |   |  |   |   |  |   |  |   |  |
| CERTIFICATE OF DEATH  |  |                             |   |   |  |   |   |  |   |  |   |  |
| 05415   |  |                             |   |   |  |   |   |  |   |  |   |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>AMBROSE JOSEPH VASOLD</b>  |  |                             |   |   |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>4 24 68</b>   |   |  | 2b. HOUR<br><b>12M</b>  |  |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b> |   | 5. DATE OF BIRTH<br><b>4-29-85</b>  |  |   | 6. AGE (In years lost birthday)<br><b>82</b> YRS. |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                         |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>BALTO., Md.</b>   |  |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  |                             |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>G.B.M.C.</b> |  |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>RETIRED</b>                              |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PAINTER</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  |                             |   | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET AND NUMBER<br><b>3211 FLEET ST. #24</b>                  |   |  |
| 14. FATHER'S NAME First Middle Last<br><b>I MARTIN VASOLD</b>   |  |                             |   |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>WINTERLING - VERNICA</b>   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>NO</b> (If yes give war or dates of service)   |  |                             |   |   |  | 16b. SOCIAL SECURITY NO.<br><b>RAILROAD RET. A-309167</b>   |   | 17. INFORMANT Address<br><b>MISS MADELINE VASOLD 3211 FLEET ST. 21224. MD.</b>   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                             |   |   |  |   |   |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY:  |  |                             |   |   |  |   |   |  |   |  |   |  |
| IMMEDIATE CAUSE (a) <b>Respiratory arrest</b>   |  |                             |   |   |  |   |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                             |   |   |  |   |   |  |   |  |   |  |
| (b) <b>Uremia</b>   |  |                             |   |   |  |   |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                             |   |   |  |   |   |  |   |  |   |  |
| (c)   |  |                             |   |   |  |   |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>792X</b>   |  |                             |   |   |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                             |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |                             |   | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |  |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |                             |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                    |  |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-22-19-68</b> to <b>4-25-19-68</b> , that (I) (we) last saw the deceased alive on <b>4-25-19-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                             |   |   |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>J. A. DECASTRO</b>   |  |                             |   |   |  |   |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4/25/68</b>                                   |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>J. A. DECASTRO</b>   |  |                             |   |   |  |   |   | 22e. ADDRESS<br><b>G.B.M.C.</b>  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |                             |   | 23b. DATE<br><b>4-29-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART CEM.</b>  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>7401 GERMAN HILL RD. BA. CO., MD.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Charles S. Jailer</b>  |  |                             |   | ADDRESS<br><b>901 S. CONKLING ST. BALTO., 21224, MD.</b>  |  |   |   | 25a. REC'D BY REGISTRAR<br><b>APR 26 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jailer</b>                  |   |  |

12419

12419

Handwritten notes, mostly illegible due to fading and bleed-through. Some words like "C. 12419" and "12419" are visible.

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|  |  |   |  |   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) Theresa  |  | First NMI   |  | Middle Vauken   |  | Last  |  | 2a. DATE OF DEATH<br>Month 4 Day 7 Year 68                                  |  |  |  | 2b. HOUR<br>M                                   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>9/29/78   |  |   |  | 6. AGE (In years<br>last birthday)<br>89 YRS.                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS                   |  | IF UNDER 24 HRS.<br>HOURS MIN.                  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Yugoslavia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Balto. Co. Gen. Hospital |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Housework |  |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Own Home |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.  |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  | 13e. STREET AND NUMBER<br>600 N. Milton Street                              |  |  |  | 13f. CITY AND STATE<br>Chapel Hill, N.C.        |  |
| 14. FATHER'S NAME<br>First Joseph  |  | Middle Padboy   |  | Last  |  | 15. MOTHER'S MAIDEN NAME<br>First Gertrude  |  | Middle Trimozic   |  | Last   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or (If yes give war or dates of service)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>217-54-6297   |  | 17. INFORMANT<br>Baltimore County General Hospital  |  |   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 486X PNEUMONIA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) FRACTURE LEFT HIP<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br>493X Arteriosclerotic Heart disease & Diabetes Mellitus  |  |   |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?     |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)                         |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)<br>NURSING HOME             |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-3, 1968, to 4-7, 1968, that (I) (we) lost<br>saw the deceased alive on 4-7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. No accident |  |   |  |   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Josue C. Laredo, MD  |  |   |  |   |  |   |  |   |  |  |  | 22c. DATE SIGNED                                |  |
| 22d. PHYSICIAN'S<br>NAME (Type) JOSUE C. LAREDO  |  |   |  |   |  |   |  |   |  |  |  | 22e. ADDRESS<br>BALTO. COUNTY GEN. HOSP.        |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>4-10-68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>KALBAUGH  |  |   |  | 23d. LOCATION (City or Town) (County) (State)<br>ELK GARDENS, WEST VIRGINIA |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>Loring Byers - 8728 Liberty Rd, Balto, MD<br>Amy Mildred Sharpless, Blaine, W.D.   |  |   |  |   |  |   |  |   |  |  |  |   |  |
| 25a. REC'D BY REGISTRAR<br>DATE APR 11 1968  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. J...   |  |   |  |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05210

UNITED STATES

1951



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1544  
30M REV. 1-66

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |                 |   |  |   |   |  |  |   |   |  |
|--|--|---|-----------------|---|--|---|---|--|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |                 |   |  |   |   |  |  |   |   |  |
| CERTIFICATE OF DEATH   |  |   |                 |   |  |   |   |  |  |   |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Mae (Marie)</b>   |  |   | First <b>E.</b> |   | Middle <b>Via</b>  |   | Last <b>Via</b>   |  | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>13</b> Year <b>68</b> |   | 2b. HOUR<br><b>7.30 PM</b>                      |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |                 | 5. DATE OF BIRTH<br><b>2-17-1900</b>  |  |   | 6. AGE (In years<br>lost birthday)<br><b>68</b> YRS.                    |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                     |   | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>St. Joseph Hospital</b> |                 |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Housewife</b> |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                 |  |   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |                 | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>1907 E. 29th Street</b> |  |   |   |  |
| 14. FATHER'S NAME<br>First <b>James</b> Middle <b>Mount</b> Last <b>Mount</b>  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Mary</b> Middle <b>Helfrich</b> Last <b>Helfrich</b>                     |                 |   |  |   |   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no or unknown <b>No</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>213-01-8982B</b>   |                 | 17. INFORMANT<br>Address<br><b>Mrs. Doris V. Muhly, 5427 Purdue Ave. #12</b>  |  |   |   |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of right breast</b><br><b>174X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic to mediastinal</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Complete atelectasis ;right lung</b><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.  |  |   |                 |   |  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>170X</b>   |  |   |                 |   |  |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                 |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |                 |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                |   |   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               |                 |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State  |   |   |  |  |   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3/30/</b> , 19 <b>68</b> , to <b>4/13/</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last<br>saw the deceased alive on <b>4/13/</b> , 19 <b>68</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the<br>causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |                 |   |  |   |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Samuel Lee, M.D.</b>  |  | DEGREE <b>M.D.</b>  |                 | ATTENDING<br>PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                       |  | 22c. DATE SIGNED<br><b>4-14-68</b>  |   |  |  |   |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>Samuel Lee, M. D.</b>  |  | 22e. ADDRESS<br><b>7620 York, Rd., Towson, Md., 21204</b>   |                 |   |  |   |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/17/68.</b>  |                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                          |   |  |  |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>  |  | ADDRESS   |                 | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 15 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |  |  |   |   |  |

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

|   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|
| 05416   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                     |  |  |  | 05418  |  |   |  |
| 1. DECEASED-NAME (Type or print) <b>MARY Alice</b> <sup>First Middle</sup>  |  |   |  |  |  | 2a. DATE OF DEATH <sup>Month Day Year</sup> <b>April 21, 1968</b>                            |  | 2b. HOUR <sup>p. m.</sup> <b>2:55</b>                   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH <b>1/20/1880</b>  |  | 6. AGE (In years <sup>at birth</sup> ) <b>88</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore</b>  |  | Md.   |  |
| 10. CITY OR TOWN OF DEATH <b>Catonsville</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Spring Grove State Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  | 13b. COUNTY <b>BALTO</b>  |  | 13c. CITY OR TOWN <b>Catonsville</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>3000 Moreland Avenue</b>      |  |
| 14. FATHER'S NAME <sup>First Middle Last</sup> <b>George Hall</b>   |  | 15. MOTHER'S MAIDEN NAME <sup>First Middle Last</sup> <b>UNKNOWN</b>  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO. <b>218-26-2674-D</b>   |  | 17. INFORMANT <b>Records: Spring Grove State Hospital</b> Address  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>551.3</b> IMMEDIATE CAUSE (a) <b>Pneumonia, right lower lobe, organism /</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>5604</b> (b) <b>Hiatus Hernia, with reflux esophagitis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>undetermined.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 days.</b><br><b>10 years</b>   |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Block.</b><br><b>Atherosclerotic Cardiovascular Ht. Dis. with Left Bundle Branch</b>  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY <sup>HOUR A.M. Month Day Year</sup> <b>19</b> P.M.  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |
| 21d. INJURY OCCURRED <sup>While at work</sup> <input type="checkbox"/> <sup>Not while at work</sup> <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                    |  | 21f. LOCATION <sup>Street or R.F.D. No. City or Town County State</sup>  |  |  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3/16/68</b> , 19 <b>68</b> , to <b>April 21, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 21, 1968</b> , and that in (my) (aur) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death. |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Anthony J. Young, M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |   |  |  |  | 22c. DATE SIGNED <b>4-22-68</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>  |  |   |  |  |  | 22e. ADDRESS <b>Spring Grove State Hospital</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE <b>4/24/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Parkland</b>   |  | 23d. LOCATION (City or town) <b>BALTO</b> (County) <b>MD</b> (State)                         |  |   |  |
| 24. FUNERAL DIRECTOR <b>Chas F. Evanson</b> ADDRESS <b>8802 Hanford Rd</b>  |  |   |  |  |  | 25a. REC'D BY REGISTRAR <b>DATE</b> <b>Apr 23 1968</b>                                       |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>         |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
304 REV. 1968

| <div>05417</div> <div> <div>1</div> <div>M</div> <div>1</div> </div> <div> <div>05419</div> <div>1</div> <div>1</div> </div>  |  |         |  |                  |   |   |  |   |  |   |  |  |  |
|---|--|---------|--|------------------|---|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |         | First  |                  | Middle  |   | Last   |   | 2a. DATE OF DEATH  |   |  | 2b. HOUR                                     |  |
| Jeannette   |  |         | O.   |                  | Votta   |   | April  |   |  | Month 14 Day 1968   |  | 3:10 PM                                      |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH |   |   |  | 6. AGE (In years lost birthday)               |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.                             |  |
| Female  |  | White   |  | 9-19-1923        |   |   |  | 47 YRS.                                       |  | MONTHS DAYS   |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH   |   |  |  |  |
| Brooklyn  |  |         |  |                  |   |   |  |   | Baltimore Md.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Baltimore   |  |         | St. Joseph Hospital  |                  |   |   | Homemaker  |   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |         | 13b. COUNTY  |                  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER   |   |  |  |  |
| Maryland  |  |         | Timonium   |                  |   |   |  |   | 28 Edgemoor Road   |   |  |  |  |
| 14. FATHER'S NAME   |  |         | First  |                  | Middle  |   | Last   |   | 15. MOTHER'S MAIDEN NAME   |   |  |  |  |
| Laurence Oppenheim  |  |         |  |                  |   |   |  |   | Cec Howland  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> (If yes give war or dates of service)  |  |         | 16b. SOCIAL SECURITY NO.   |                  |   | 17. INFORMANT   |  |   |  |   |  |  |  |
| Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> (If yes give war or dates of service)   |  |         | 217 12 7173  |                  |   | Larence G. Votta, 28 Edgemoor Rd. 21093   |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |  |                  |   |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |  |         |  |                  |   |   |  |   |  |   |  |  |  |
| IMMEDIATE CAUSE (a) Bilateral confluent bronchopneumonia  |  |         |  |                  |   |   |  |   |  |   |  |  |  |
| 3480 DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |                  |   |   |  |   |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Amyotrophic lateral sclerosis  |  |         |  |                  |   |   |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |         |  |                  |   |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |         |  |                  |   |   |  |   |  |   |  |  |  |
| 3561  |  |         |  |                  |   |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  |   |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |         | 21b. TIME OF INJURY  |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |   |  |   |  |  |  |
|   |  |         | HOUR A.M. Month Day Year P.M. 19   |                  |   |   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  |   | 21f. LOCATION   |  | Street or R.F.D. No.                          |  | City or Town  |  | County State                                 |  |
|   |  |         |  |                  |   |   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-7-1968, to 4-14-1968, that (I) (we) last saw the deceased alive on 4-14-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |         |  |                  |   |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE  |  |         |  |                  |   |   |  | DEGREE  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED                             |  |
| Lawrence Misanik, M.D.  |  |         |  |                  |   |   |  |   |  |   |  | 4-15-68                                      |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |         |  |                  |   |   |  | 22e. ADDRESS                                  |  |   |  |  |  |
|   |  |         |  |                  |   |   |  | 7620 York Road, Baltimore, Maryland 21204     |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |         | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY  |   |  | 23d. LOCATION (City or Town) (County) (State) |  |   |  |  |  |
| Burial  |  |         | 4-17-1968  |                  | Dulaney Valley  |   |  | Cockeysville, Md.                             |  |   |  |  |  |
| 24. FUNERAL DIRECTOR  |  |         |  |                  |   |   |  | ADDRESS                                       |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                   |  |
| Wm. Cook-Brooks Towson, Towson, Md. 21204   |  |         |  |                  |   |   |  |   |  | DATE APR 17 1968  |  | Charles Judge                                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <span>05418</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>05420</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>   |  |   |  |   |  |   |  |  |  |  |   |
|--|--|---|--|---|--|---|--|--|--|--|---|
| 1. DECEASED-NAME (Type or print) <b>MARION</b> <sup>First</sup> <b>HAYS</b> <sup>Middle</sup> <b>WALGER</b> <sup>Last</sup>  |  |   |  |   |  | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>29</b> Year <b>68</b>  |  |  | 2b. HOUR <b>10:30</b> M <b>P</b>                   |  |   |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br><b>2/12/95</b>  |  |   | 6. AGE (In years last birthday)<br><b>73</b> YRS.                      |  | IF UNDER 1 YEAR<br>MONTHS <b>73</b> DAYS <b>73</b> |  | IF UNDER 24 HRS.<br>HOURS <b>73</b> MIN <b>73</b> |
| 7a. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.                             |  |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GREATER BALT. MED. CENT.</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>NONE</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                    |  |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>—</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>3206 PARKSIDE DRIVE</b> |  |  |   |
| 14. FATHER'S NAME <sup>First</sup> <b>WILLIAM</b> <sup>Middle</sup> <b>LAZARUS</b> <sup>Last</sup> <b>COSTEN</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME <sup>First</sup> <b>BEULAH</b> <sup>Middle</sup> <b>INEZ</b> <sup>Last</sup> <b>HAYS Hayes</b>                                     |  |   |  |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-05-2308</b>  |  | 17. INFORMANT<br><b>PATIENT'S CHART</b>   |  |   |  | Address  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Respirators failure</b><br><b>180X</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>eczema</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>171X</b>   |  |   |  |   |  |   |  |  |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                        |   |  |  |  |  |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                    |  |   | 21f. LOCATION Street or R.F.D. No.   |   | City or Town   |  | County   |  | State   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-27</b> , 19 <b>68</b> , to <b>4-29</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-30-P.M.</b> <b>1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.       |  |   |  |   |  |   |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Rahim Bassiri</b>   |  |   |  |   |  | DEGREE <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4-29-68</b>                   |  |  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Rahim Bassiri</b>   |  |   |  |   |  | 22e. ADDRESS  |  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/3/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>  |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |  |  |  |   |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks West Inc Balt. Md. 21228</b>  |  |   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>MAY 6 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |                          |  |   |  |  |                                   |  |
|---|--|--|--------------------------|--|---|--|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                          |  |   |  |  |                                   |  |
| CERTIFICATE OF DEATH  |  |  |                          |  |   |  |  |                                   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last        |  |   | 20. DATE OF DEATH  |  |                                   | 2b. HOUR                                     |
| Donald Eugene Ward  |  |  |                          |  |   | April Month 9 Day Year 68  |  |                                   | 4:40 <sup>P</sup>                            |
| 3. SEX  |  | 4. RACE  |                          | 5. DATE OF BIRTH   |   |  | 6. AGE (In years lost birthday)                                      |                                   | IF UNDER 1 YEAR MONTHS DAYS                  |
| Male  |  | White  |                          | 8-25-29  |   |  | 38 YRS.  |                                   | IF UNDER 24 HRS. HOURS MIN.                  |
| 70. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |                                   |  |
| Baltimore   |  | U.S.A.   |                          |  |   | Baltimore Md.  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          |  | 120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| (Baltimore) Towson  |  | St. Joseph Hospital  |                          |  | Gas Station attendant   |  |  | Station Owner                     |  |
| 130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER            |  |
| Baltimore   |  |  |                          | Baltimore  |   |  |  | 4831 Truesdale Avenue             |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME |  |   |  |  |                                   |  |
| First Middle Last   |  |  | First Middle Last        |  |   |  |  |                                   |  |
| Eugene Ward   |  |  | Nellie Pangle            |  |   |  |  |                                   |  |
| 160. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (specify) No (unknown)  |  |  | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT Address   |  |  |                                   |  |
| yes Korean  |  |  | 214-24-8906              |  | Nancy Ward Same   |  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Ruptured anterior communicating artery<br>442 X DUE TO, OR AS A CONSEQUENCE OF aneurysm-stress ulcer<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>453 X |  |  |                          |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |  |
| 210. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                          |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |  |                                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |  |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-30-68, 19-68, to 4-9-68, 19-68, that (X) (we) last saw the deceased alive on 4/9/68, 19-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |                          |  |   |  |  |                                   |  |
| 22b. SIGNATURE  |  |  |                          |  | 22c. DATE SIGNED  |  |  |                                   |  |
| Juan Gan, M.C.  |  |  |                          |  | 4/9/68  |  |  |                                   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |                          |  | 22e. ADDRESS  |  |  |                                   |  |
| Juan Gan, M.C.  |  |  |                          |  | 7620 York Rd., Towson, Md.  |  |  |                                   |  |
| 230. BURIAL, CREMATION, or other disposition  |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |                                   |  |
| Burial  |  | 4/13/68  |                          | Moreland Mem. Pk.  |   | Balto. Md.   |  |                                   |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |                          |  | 250. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |                                   |  |
| Leonard J. Ruck Inc. Balto. Md.   |  |  |                          |  | DATE APR 11 1968  |  | Charles Judge  |                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

|  |  |  |                     |   |  |  |  |   |                                   |
|--|--|--|---------------------|---|--|--|--|---|-----------------------------------|
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br><b>Florence</b>   | Middle<br><b>G.</b> | Last<br><b>Warfield</b>   | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>10</b> Year <b>1968</b>               |  | 2b. HOUR<br><b>11A</b> M   |   |                                   |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>  |                     | 5. DATE OF BIRTH<br><b>10/16/1878</b>   |  | 6. AGE (In years last birthday)<br><b>89</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                     | IF UNDER 24 HRS.<br>HOURS<br>MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Prince Frederick, Md. (U.S.A.)</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |   |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore 21212</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Armecost Nursing Home</b> |                     | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired-Public Schools-</b>                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Teaching</b>   |  |   |                                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |                     | 13c. CITY OR TOWN<br><b>Ruxton</b>  |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>1501 Carrollton Ave.</b> |                                   |
| 14. FATHER'S NAME<br>First <b>Andrew</b> Middle <b>J.</b> Last <b>Gill</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Kate</b> Middle <b>Luman</b> Last <b>Luman</b>                          |                     |   |  |  |  |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>220-44-7531</b>   |                     | 17. INFORMANT<br><b>Mrs. D. H. Hamilton</b>   |  | Address<br><b>(Same)</b>   |  |   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Generalized Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 1/2 days</b><br><b>10 yrs</b> |  |  |                     |   |  |  |  |   |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>  |  |  |                     |   |  |  |  |   |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                     |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |                                   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |                     | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |                                   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                 |                     | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/10/1968</b> to <b>4/11/1968</b> , that <b>we</b> last saw the deceased alive on <b>4/10/1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <b>we</b> (we) (did) (did not) view the body after death.  |  |  |                     |   |  |  |  |   |                                   |
| 22b. SIGNATURE<br><b>Charles F. O'Donnell</b>  |  | DEGREE   |                     | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>4/11/68</b>   |  |   |                                   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Charles F. O'Donnell</b>  |  | 22e. ADDRESS<br><b>7501 York Road</b>  |                     |   |  |  |  |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/13/68</b>  |                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland, Maryland</b>                           |  |   |                                   |
| 24. FUNERAL DIRECTOR<br><b>H. W. Jenkins &amp; Sons Co.</b>  |  | ADDRESS<br><b>4905 York Rd. Balto. 12, Md.</b>   |                     | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 15 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |                                   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

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VR 151  
30M REV 11-68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |         |   |                  |  |   |                                    |   |   |                        |                                |              |  |  |
|--|--|---------|---|------------------|--|---|------------------------------------|---|---|------------------------|--------------------------------|--------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |         |   |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| CERTIFICATE OF DEATH   |  |         |   |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |         | First Middle Last   |                  |  | 2a. DATE OF DEATH   |                                    |   | 2b. HOUR  |                        |                                |              |  |  |
| LINN REANEY WARFIELD   |  |         |   |                  |  | Month Day Year  |                                    |   | 9:50 P.M.   |                        |                                |              |  |  |
| 3. SEX   |  | 4. RACE |   | 5. DATE OF BIRTH |  |   | 6. AGE (In years<br>last birthday) |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |                        | IF UNDER 24 HRS.<br>HOURS MIN. |              |  |  |
| FEMALE   |  | CAU.    |   | 1-16-09          |  |   | 59 YRS.                            |   |   |                        |                                |              |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  |         | 7b. CITIZEN OF WHAT COUNTRY?  |                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |   | 9. COUNTY OF DEATH  |                        |                                |              |  |  |
| MARYLAND   |  |         | U.S.A.  |                  |  |   |                                    |   | BALTIMORE   |                        |                                | Md.          |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |                  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |                                    |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |                        |                                |              |  |  |
| TOWSON, MD.  |  |         | GREATER BALTIMORE MED.  |                  |  | HOUSEWIFE   |                                    |   |   |                        |                                |              |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  |         | 13b. COUNTY   |                  |  | 13c. CITY OR TOWN   |                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER |                                |              |  |  |
| MD.  |  |         | BALTIMORE   |                  |  | RUXTON  |                                    |   |   | 27 MURRAY HILL CIRCLE  |                                |              |  |  |
| 14. FATHER'S NAME  |  |         | 15. MOTHER'S MAIDEN NAME  |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| First Middle Last  |  |         | First Middle Last   |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| JAMES - REANEY   |  |         | JULIA - YON RIESEN  |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)   |  |         | 16b. SOCIAL SECURITY NO.  |                  |  | 17. INFORMANT   |                                    |   | Address   |                        |                                |              |  |  |
| NO   |  |         | 213-38-5456   |                  |  | ADMISSION SHEET   |                                    |   | G.B.M.C.  |                        |                                |              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |   |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |         |   |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| IMMEDIATE CAUSE (a)  |  |         |   |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| 1579 DUE TO, OR AS A CONSEQUENCE OF  |  |         |   |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |         |   |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| (b) Generalized metastases   |  |         |   |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |   |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| (c) Carcinoma of Pancreas  |  |         |   |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |         |   |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| 157X   |  |         |   |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| 19a. DATE OF OPERATION   |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |                  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                    |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?   |                        |                                |              |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                    |   |   |                        |                                |              |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |         | 21e. PLACE OF INJURY (At home, farm, street, factory,<br>office building, etc.) |                  |  | 21f. LOCATION Street or R.F.D. No.  |                                    |   | City or Town  |                        |                                | County State |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 29 Jan., 1968, to 4, 10, 1968, that (I) (we) last saw the deceased alive on 4, 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |         |   |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| 22b. SIGNATURE   |  |         | 22c. DATE SIGNED  |                  |  | DEGREE  |                                    |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                        |                                |              |  |  |
| MAGHAM M.D.  |  |         | 8-10-68   |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |         | 22e. ADDRESS  |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| MAGHAM M.D.  |  |         | Greater Baltimore Medical Center<br>6701 N. Charles Street                      |                  |  |   |                                    |   |   |                        |                                |              |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  |         | 23b. DATE   |                  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                    |   | 23d. LOCATION (City or Town) (County) (State)   |                        |                                |              |  |  |
| Burial   |  |         | 4-13-68   |                  |  | Greenmount  |                                    |   | Baltimore Maryland  |                        |                                |              |  |  |
| 24. FUNERAL DIRECTOR   |  |         | ADDRESS   |                  |  | 25a. REC'D BY REGISTRAR   |                                    |   | 25b. REGISTRAR'S SIGNATURE  |                        |                                |              |  |  |
| H.W.Jenkins & Sons Co.   |  |         | 4905 York Rd.   |                  |  | DATE APR 15 1968  |                                    |   | Charles Judge   |                        |                                |              |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

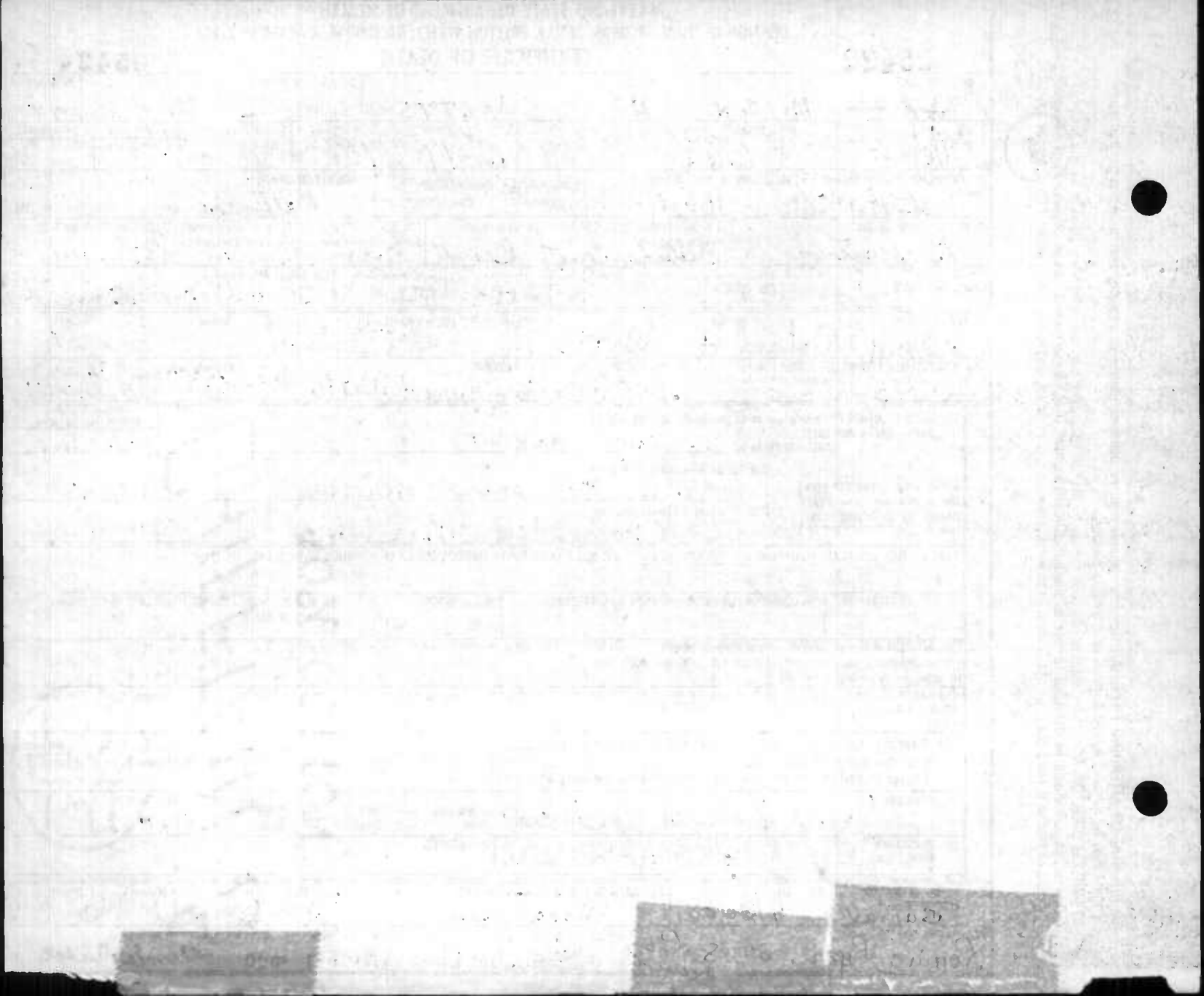
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |                      |  |  |
|--|----------------------|--|--|
| 05422  |                      | 05424  |  |
| 1. DECEASED-NAME (Type or print) <b>WATTS, MILTON A.</b>   |                      | 2a. DATE OF DEATH Month <b>4</b> Day <b>27</b> Year <b>68</b>  |  |
| 3. SEX <b>Male</b>   | 4. RACE <b>White</b> | 2b. HOUR <b>7 P M</b>  |  |
| 5. DATE OF BIRTH <b>12-19-1900</b>   |                      | 6. AGE (In years last birthday) <b>67</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country) <b>USA MD.</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |                      | 9. COUNTY OF DEATH <b>Baltimore</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH <b>Randallstown</b>  |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Baltimore County General</b> |  |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Grocer</b>  |                      | 12b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>   |                      | 13b. CITY OR TOWN <b>Balto.</b>  |  |
| 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                      | 13d. STREET AND NUMBER <b>3800 Lochearn Drive</b>  |  |
| 14. FATHER'S NAME First <b>Richard A.</b> Middle <b>Watts</b> Last <b>French</b>   |                      | 15. MOTHER'S MAIDEN NAME First <b>Elleanor</b> Middle <b>French</b> Last <b>French</b>                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)   |                      | 16b. SOCIAL SECURITY NO. <b>705-10-6474</b>  |  |
| 17. INFORMANT <b>Mrs. Anna A. Watts</b>  |                      | Address <b>3800 Lochearn Drive Balto. Md. 21207</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |                      |  |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac ARREST</b>   |                      |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASHD, pulmonary congestion</b>   |                      |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>carcinoma, left upper lobe</b>   |                      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |                      |  |  |
| 19a. DATE OF OPERATION <b>1621</b>   |                      |  |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                      | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                      |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |                      | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>  |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |                      |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |                      | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                 |  |
| 21f. LOCATION Street or R.F.D. No. City or Town County State   |                      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                      |  |  |
| 22b. SIGNATURE <b>Jose A. Raquel Jr. M.D.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |                      | 22c. DATE SIGNED <b>4/27/68</b>  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>JOSE A. RAQUEL JR. M.D.</b>  |                      | 22e. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                      | 23b. DATE <b>4/30/68</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>   |                      | 23d. LOCATION (City or Town) (County) (State) <b>Woodlawn, Md.</b>   |  |
| 24. FUNERAL DIRECTOR <b>Doning Byers, 8728 Liberty Rd. Randallstown Md.</b>  |                      | 25a. REC'D BY REGISTRAR <b>DATE</b>  |  |
| 25b. REGISTRAR'S SIGNATURE <b>William Judge</b>  |                      |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)-  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |   |  |   |  |  |  |   |  |   |  |
|--|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Andrew</i>  |  | First <i>Andrew</i>   |  | Middle <i>Webster</i>   |  | Last <i>Webster</i>  |  | 2a. DATE OF DEATH<br>Month <i>April</i> Day <i>4</i> Year <i>1968</i> |  | 2b. HOUR<br><i>4:30</i> P   |  |
| 3. SEX<br><i>male</i>  |  | 4. RACE<br><i>white</i>   |  | 5. DATE OF BIRTH<br><i>May 6, 1887</i>  |  | 6. AGE (In years last birthday)<br><i>80</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                              |  | IF UNDER 24 HRS.<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>MD.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Parkville</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>3337 Garnet Road</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><i>Ret. Chief Operating Engr.</i>                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>  |  | 13b. COUNTY<br><i>Baltimore</i>   |  | 13c. CITY OR TOWN<br><i>Parkville</i>   |  | 13d. INSIDE CITY LIMITS<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>3337 Garnet Road</i>                     |  |   |  |
| 14. FATHER'S NAME<br><i>Andrew J. Webster</i>  |  | First <i>Andrew</i>   |  | Middle <i>J.</i>  |  | Last <i>Webster</i>  |  | 15. MOTHER'S MAIDEN NAME<br><i>Diana A. Tolly</i>                     |  | First <i>Diana</i> Middle <i>A.</i> Last <i>Tolly</i>                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><i>NO</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>220-07-267</i>   |  | 17. INFORMANT<br>Address<br><i>MR. Wayne W. Webster - Same</i>  |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i><br><i>4129</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Arteriosclerotic Cardiovascular Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 days</i><br><i>20 days</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>4221 Abdominal Aortic Aneurysm</i>  |  |   |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>                                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1946</i> , to <i>April 3, 1968</i> , that (I) (we) last saw the deceased alive on <i>April 3, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Thomas J. Brennan</i>   |  | 22c. DATE SIGNED<br><i>5 April 1968</i>   |  | 22d. PHYSICIAN'S NAME (Type)<br><i>THOMAS J. BRENNAN, M.D.</i>  |  |  |  |   |  |   |  |
| 22e. ADDRESS<br><i>5217 Harford Road Balto Md 21214</i>  |  |   |  |   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 23b. DATE<br><i>4/8/68</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Parkwood Cemetery</i>  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Md.</i>                         |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>Leonard J. Ruck, Inc Baltimore, Md.</i>   |  | ADDRESS   |  | 25a. PREPARED BY REGISTRAR<br><i>APR 9 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Judge</i>   |  |   |  |   |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |                   |   |   |   |  |   |  |
|--|--|--|--|---|-------------------|---|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |                   |   |   |   |  |   |  |
| CERTIFICATE OF DEATH   |  |  |  |   |                   |   |   |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <u>Helen R. West</u>   |  |  | 2a. DATE OF DEATH<br><u>April</u> Month <u>11</u> Day <u>1968</u> Year                                     |   |                   | 2b. HOUR<br>M   |   |   | 05426  |   |  |
| 3. SEX<br><u>Female</u>  |  | 4. RACE<br><u>White</u>  |  | 5. DATE OF BIRTH<br><u>JULY 9, 1904</u>   |                   | 6. AGE (In years last birthday)<br><u>63</u> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  | IF UNDER 24 HRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><u>Balto. Md</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. COUNTY OF DEATH<br><u>Baltimore</u> Md.  |   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>3626 Forest Hill Rd</u> |   |                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>Housewife</u> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                    |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><u>3626 Forest Hill Rd</u>  |  |  | 13b. COUNTY<br><u>Balto.</u>   |   | 13c. CITY OR TOWN |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><u>3626 Forest Hill Rd</u> |   |  |
| 14. FATHER'S NAME<br>First <u>John</u> Middle <u>H.</u> Last <u>Reich</u>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <u>Sadie Z.</u> Middle <u>Miller</u> Last                                |   |                   |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <u>NO</u>  |  |  | 16b. SOCIAL SECURITY NO.<br><u>NONE</u>  |   |                   | 17. INFORMANT<br>Name <u>Mr. Edwin H. Reich</u> Address <u>Balto. Md</u><br><u>-3626 Forest Hill Rd</u>     |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cornary Arteriosclerosis</u><br><u>4109</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |                   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 yrs -</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>4201 Resident pneumonia</u>   |  |  |  |   |                   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>19</u>            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                   |   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                   |   |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 1937</u> , to <u>April 11, 1968</u> , that (I) (we) lost saw the deceased alive on <u>April 10, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |                   |   |   |   |  |   |  |
| 22b. SIGNATURE<br><u>Dr. Leon A. Kochman</u>   |  | DEGREE   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |                   | 22c. DATE SIGNED<br><u>4-11-68</u>  |   |   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Dr. Leon A. Kochman</u>   |  | 22e. ADDRESS<br><u>1214 N. Calvert St</u>                                    |  |   |                   |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE<br><u>4/13/68</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Inwood Ridge</u>   |                   | 23d. LOCATION (City or Town) (County) (State)<br><u>Pikesville Md</u>                                       |   |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>Loring Byers-8728 Liberty Road</u>  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>APR 15 1968</u>  |                   | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>   |   |   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1514  
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Margaret</i>   |  | First Middle Last  |  | 2a. DATE OF DEATH<br><i>April</i> Month <i>14</i> Day <i>1968</i>   |  | 2b. HOUR<br>M  |  |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br><i>March 31, 1898</i>   |  | 6. AGE (In years last birthday)<br><i>70</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Baltimore</i>   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Carney</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>9404 Ridgely Rd</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Housekeeper</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Hospital</i>   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md.</i>  |  | 13b. COUNTY <i>Balto.</i>  |  | 13c. CITY OR TOWN <i>Balto.</i>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>9404 Ridgely Rd</i>                               |  |
| 14. FATHER'S NAME<br>First Middle Last<br><i>Thomas Lambdin</i>   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><i>Minnie ?</i>                                       |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, name of unit (If yes give war or dates of service)<br><i>None</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>212-09-3423</i>   |  | 17. INFORMANT<br><i>Dr Fred West</i>  |  | Address<br><i>Same</i>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><i>4109</i> IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Rectal fissure + hemorrhoids</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 Day</i><br><i>Dec. 67</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>4201</i>   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><i>2-21-68</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>hernia - anus</i>                               |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>                                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-1-68</i> , 19__, to <i>4-8-68</i> , 19__, that (I) (we) last saw the deceased alive on <i>4-8-68</i> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>W Wallace Walker M.D.</i>  |  | DEGREE   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><i>2-16-68</i>   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>W. Wallace Walker M.D.</i>   |  | 22e. ADDRESS<br><i>Medical Arts Bldg. Balto. Md.</i>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Cremation</i>   |  | 23b. DATE<br><i>4/17/68</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Greenmount</i>   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Maryland</i>                  |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Leonard J Ruck Inc. Baltimore, Md</i>  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE <i>APR 16 1968</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |  |  |

UNITED STATES DEPARTMENT OF AGRICULTURE

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 05426   |  |  |  | 05428   |  |  |  |   |  |  |  |
| 1. DECEASED-NAME (Type or print)  |  |  |  | 2a. DATE OF DEATH   |  |  |  | 2b. HOUR  |  |  |  |
| First Middle Last<br><b>RUPERT HALL WILLIAMS SR.</b>  |  |  |  | Month Day Year<br><b>APRIL 26 1968</b>  |  |  |  | 5:45 PM   |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR                                 |  | IF UNDER 24 HRS.   |  |
| MALE  |  | NEGROID  |  | JANUARY 12, 1896  |  | 72 YRS.  |  | MONTHS DAYS                                     |  | HOURS MIN  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |   |  |  |  |
| MARYLAND  |  | U.S.A.   |  |   |  | BALTIMORE Md.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |
| FORT HOWARD   |  | VETERANS ADMINISTRATION HOSPITAL   |  | COOK  |  | Retired  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)   |  | 13b. CITY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                          |  |  |  |
| MARYLAND  |  | BALTIMORE  |  | BALTIMORE   |  |  |  | 133 E. CHESAPEAKE AVENUE                        |  |  |  |
| 14. FATHER'S NAME First Middle Last   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last  |  |  |  |   |  |  |  |
| HORATIO WILLIAMS  |  |  |  | AUGUSTA JOHNSON   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | Address  |  |   |  |  |  |
| YES   |  | WW I   |  | 217 05 6288   |  | VA HOSPITAL  |  | CLINICAL RECORDS, FORT HOWARD, MARYLAND         |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PULMONARY EDEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4109</b>                    |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 DAYS</b><br><b>10 DAYS</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>4201 DIABETES MELLITUS</b>  |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/14/68</b> , 19__, to <b>4/26/68</b> , 19__, that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>4/26/68</b> , 19__, and that in <b>XXXX</b> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE <b>Alfonso A. Lopez</b>  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |  | 22c. DATE SIGNED <b>4 26 68</b>  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>ALFONSO A. LOPEZ, M.D.</b>  |  |  |  | 22e. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |   |  |  |  |
| BURIAL  |  | <b>5/1/68</b>  |  | BALTIMORE NATIONAL  |  | BALTIMORE, MARYLAND  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR <b>Wm CHATMAN FUNERAL HOME, 1701 MCCULLOH ST</b>   |  |  |  | ADDRESS <b>BALTO, MD</b>  |  | 25a. REC'D BY REGISTRAR <b>APR 29 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b> |  |  |  |

ESTATE OF DAVID

# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05427

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

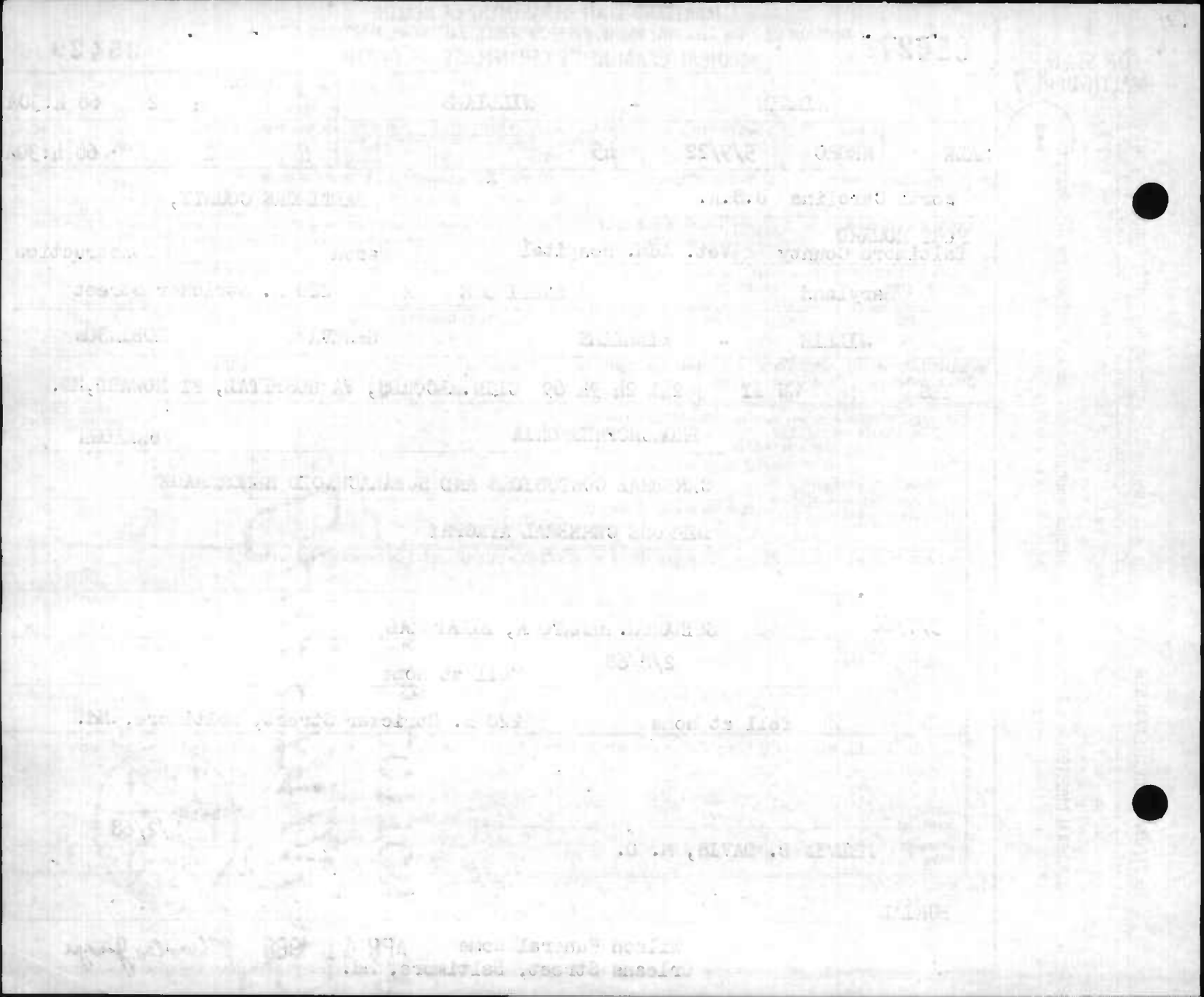
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05429

|  |                         |   |   |   |  |  |  |
|--|-------------------------|---|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |                         | First<br><b>WILLIE</b>  | Middle<br><b>-</b>                                | Last<br><b>WILLIAMS</b>   | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month <b>4</b> Day <b>2</b> Year <b>1968</b> |  | 2b. HOUR<br><b>4:30A</b>                                       |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>NEGRO</b> | 5. DATE OF BIRTH<br><b>5/9/22</b>   | 6. AGE (In years last birthday)<br><b>45</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>   | 2c. DATE PRONOUNCED DEAD<br>Month <b>4</b> Day <b>2</b> Year <b>1968</b>                     | 2d. HOUR<br><b>4:30A</b>                                       |
| 7a. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY,</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD Baltimore County</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Vet. Adm. Hospital</b>   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Mason</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>                                     |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>220 N. Stricker Street</b>  |                         | 14. FATHER'S NAME<br>First <b>WILLIE</b> Middle <b>-</b> Last <b>WILLIAMS</b>                               |   | 15. MOTHER'S MAIDEN NAME<br>First <b>GENEVA</b> Middle <b>-</b> Last <b>ROBINSON</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>YES</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>WW 11</b>  |   | 17. INFORMANT<br><b>CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>   |  | ADDRESS  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br><b>887X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>CEREBRAL CONTUSIONS AND SUBARACHNOID HEMORRHAGE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>DIFFUSE CEREBRAL ATROPHY</b> |                         |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>9040</b>   |                         |   |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>3/7/68</b>  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>SUBDURAL HEMATOMA, BILATERAL</b>                    |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                         | 21b. TIME OF INJURY Month, Day, Year<br>Month <b>2</b> Day <b>8</b> Year <b>1968</b><br>A.M. <b>19</b> P.M. |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Fell at home</b>  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>fell at home</b>         |   | 21f. LOCATION Street or R.F.D. No. <b>220 N. Stricker Street, Baltimore, Md.</b><br>City or Town <b>Baltimore</b> County <b>Baltimore</b> State <b>Md.</b>            |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                        |                         |   |   |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Melvin B. Davis</b>   |                         | EXAMINER'S NAME (Type)<br><b>MELVIN B. DAVIS, M. D.</b>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br><b>4/2/68</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         | 23b. DATE<br><b>4-5-68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Nat - Cut</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md</b>                         |  |
| 24. FUNERAL DIRECTOR<br><b>Wilson Funeral Home</b><br><b>Orleans Street, Baltimore, Md.</b>  |                         | ADDRESS   |   | 25a. REC'D BY REGISTRAR<br><b>APR 4 - 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

MEDICAL CERTIFICATION

FINAL BURIAL PLACE - NORTH CAROLINA  
A34 RET. 6/27/68



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| M 05423   |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 05430                       |  |  |  |
|---|--|--|--|--|--|--|--|-----------------------------|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last  |  |  |  | 2a. DATE OF DEATH Month Day Year   |  |  |  | 2b. HOUR                    |  |  |  |
| HELEN MILDRED WILSON  |  |  |  | Month 4 Day 1 Year 68  |  |  |  | 4:58 M                      |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday) YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| FEMALE  |  | Caucasian  |  | 10-15-12   |  | 55   |  |                             |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                             |  |  |  |
| BALTO., MD.   |  | U.S.A.   |  |  |  | BALTO. Co. Md.   |  |                             |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                             |  |  |  |
| Towson  |  | GBMC   |  | HOUSEWIFE  |  | OWN HOME   |  |                             |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER      |  |  |  |
| MD.   |  | BALTO.   |  | BALTO. CITY  |  | YES  |  | 1646 BALTO. MD. 21218       |  |  |  |
| 14. FATHER'S NAME First Middle Last   |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |  |  |  |  |  |                             |  |  |  |
| William H. SHELTON  |  | MARGARET GREEN SHELTON   |  |  |  |  |  |                             |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |  |  |  |                             |  |  |  |
| NO  |  | 216-01-5588  |  | RUDOLPH L. WILSON (BAME)   |  |  |  |                             |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u>   |  |  |  |  |  |  |  |                             |  |  |  |
| 149X DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hemophysis</u>   |  |  |  |  |  |  |  |                             |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Carcinoma of pharynx</u>  |  |  |  |  |  |  |  |                             |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |                             |  |  |  |
| 148X  |  |  |  |  |  |  |  |                             |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                             |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |                             |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |                             |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4.1.1968</u> , to <u>4.1.1968</u> , that (I) (we) last saw the deceased alive on <u>4.1.1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |                             |  |  |  |
| 22b. SIGNATURE <u>Dipak Kumar Mallik</u>  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <u>4.1.68</u>   |  |  |  |                             |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>DIPAK KUMAR MALLIK</u>  |  | 22e. ADDRESS <u>G. B. M. C.</u>  |  |  |  |  |  |                             |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE <u>4/4/68</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>  |  | 23d. LOCATION (City or Town) (County) (State) <u>Woodlawn, Balto. Co., Md.</u>               |  |                             |  |  |  |
| 24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>   |  | 4905 York Rd. Balto. 12, Md.   |  | 25a. REC'D BY REGISTRAR <u>APR 3 - 1968</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |                             |  |  |  |

[Faint, mostly illegible text covering the main body of the page, appearing to be a report or document.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |   |   |   |  |  |  |
|--|--|--|---|---|---|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |   |   |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>ELSIE MARGARET WINEBRENNER</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>30</b> Year <b>1968</b>          |   |   | 2b. HOUR<br><b>11:55 PM</b>   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>  |   | 5. DATE OF BIRTH<br><b>2/24/18</b>  |   | 6. AGE (In years<br>last birthday)<br><b>50</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.        |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>G.B.M.C.</b>  |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>HOUSEWIFE</b>  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>MARYLAND</b>   |  | 13b. COUNTY <b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>9604 DIXON AVE.</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>JOHN FRISBY</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>HOOVER MARGARET HOOVER</b> |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>21822-5523</b>                               |   | 17. INFORMANT Address<br><b>PATIENT'S CHART /</b> |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>possible brain metastases</b><br><b>180X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) <b>Pulmonary Metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Carcinoma of the Cervix Grade IV.</b><br><b>171X</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-29</b> , 19 <b>68</b> , to <b>4-30</b> , 19 <b>68</b> , that (I) (we) last<br>saw the deceased alive on <b>4-30</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>E.R. Soudijn</b>  |  | DEGREE ATTENDING<br>PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5-1-68</b>   |   |   |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>E.R. Soudijn</b>  |  | 22e. ADDRESS<br><b>GRAETER BALTIMORE MED CENTRE</b>  |   |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE<br><b>5/3/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Natl Cem.</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>                           |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. 5305 Harford Rd.</b>   |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>MAY 1 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

05433

RECEIVED OF D. 101

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BALTIMORE

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MAY 1964  
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MAY 1964  
BALTIMORE

PATIENTS CHART

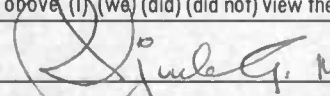
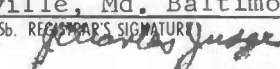
DO NOT WRITE IN THESE SPACES

MAY 1 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1574  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |  |  |   |  |
|---|--|--|--|---|--|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |  |  |   |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br>NAOMI   |  | Middle<br>MARGUERITE  |  | Last<br>WINTER  |  | 2a. DATE OF DEATH<br>Month Day Year<br>APRIL 2, 1968 |  | 2b. HOUR<br>2:50 M                              |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>DECEMBER 26, 1906   |  | 6. AGE (In years<br>last birthday)<br>61 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                       |  | IF UNDER 24 HRS.<br>HOURS MIN                   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE, Md.  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>ST. JOSEPH HOSPITAL |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired)<br>HOMEMAKER Secretary  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>Timonium   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>324 E. TIMONIUM RD. #21093 |  |   |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Thomas U. Forrest   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Laura Kuhne   |  |   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>213-44-9545  |  | 17. INFORMANT<br>Address<br>Mr. Ralph A. Winter 324 E. Timonium Rd.   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>1538 IMMEDIATE CAUSE (a) Abdominal carcinomatosis, primary in colon<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last, 1538 |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Intestinal obstruction  |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                        |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |   |  |  |  |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from MARCH 22, 1968, to APRIL 2, 1968, that (X) (we) last<br>saw the deceased alive on APRIL 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>   |  | 22c. DATE SIGNED<br>April 2, 1968  |  | 22d. PHYSICIAN'S<br>NAME (Type) Reynaldo Orjuela-Gomez, M.D. 22e. ADDRESS<br>7620 York Rd., Towson, Md. 21204   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>4/5/68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Cockeysville, Md. Baltimore                    |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Wm. Cook-Brooks Towson 1050 York Rd. 21204   |  | 25a. REC'D BY REGISTRAR<br>DATE APR 3 - 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>   |  |   |  |  |  |   |  |

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(14)

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## CERTIFICATE OF DEATH

2. DATE AND HOUR OF DEATH

1. NAME OF DECEASED

(Type or Print)

ISADORE (ISADOR) (ISIDOR) WOLFF

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4315 LABYRINTH ROAD, APT. 1 B

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4315 LABYRINTH ROAD, APT. 1 B

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

8. DATE OF BIRTH

MAY 26, 1899

9. AGE (In years last birthday)

68

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SALVAGE

10B. KIND OF BUSINESS OR INDUSTRY

METAL

11. BIRTHPLACE (State or foreign country)

RUSSIA

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

NATHAN WOLFF

14. MOTHER'S MAIDEN NAME

GUSSIE TURNER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

214-16-4955

17. INFORMANT

MR. HOWARD RUBIN, 4315 LABYRINTH RD.

ADDRESS

APT. 1A

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Generalized Carcinoma

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 months

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Carcinoma of Stomach

6 months

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

22. I certify that (I) (this hospital) attended the deceased from 3/11 1948 to 7/6 1968 that (I) (we) last saw the deceased alive on 4/6 1968 and that in (my) (our) opinion death occurred on the date stated and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

Israel Zinberg

DEGREE

Attending Phys. ☒Med. Director ☐Staff Phys. ☐

23B. DATE SIGNED

4/6/68

23D. ADDRESS

4000 W. Northern Parkway

DEGREE

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

4-7-68

24C. NAME of CEMETERY or CREMATORY

BETH YEHUDA ANSHE KURLAND

24D. LOCATION

(City, town, or county)

BALTIMORE, MARYLAND

(State)

VR 25A. DATE REC'D BY HEALTH DEPT. 30M R

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

SOL LEVINSON &amp; BROS. INC.

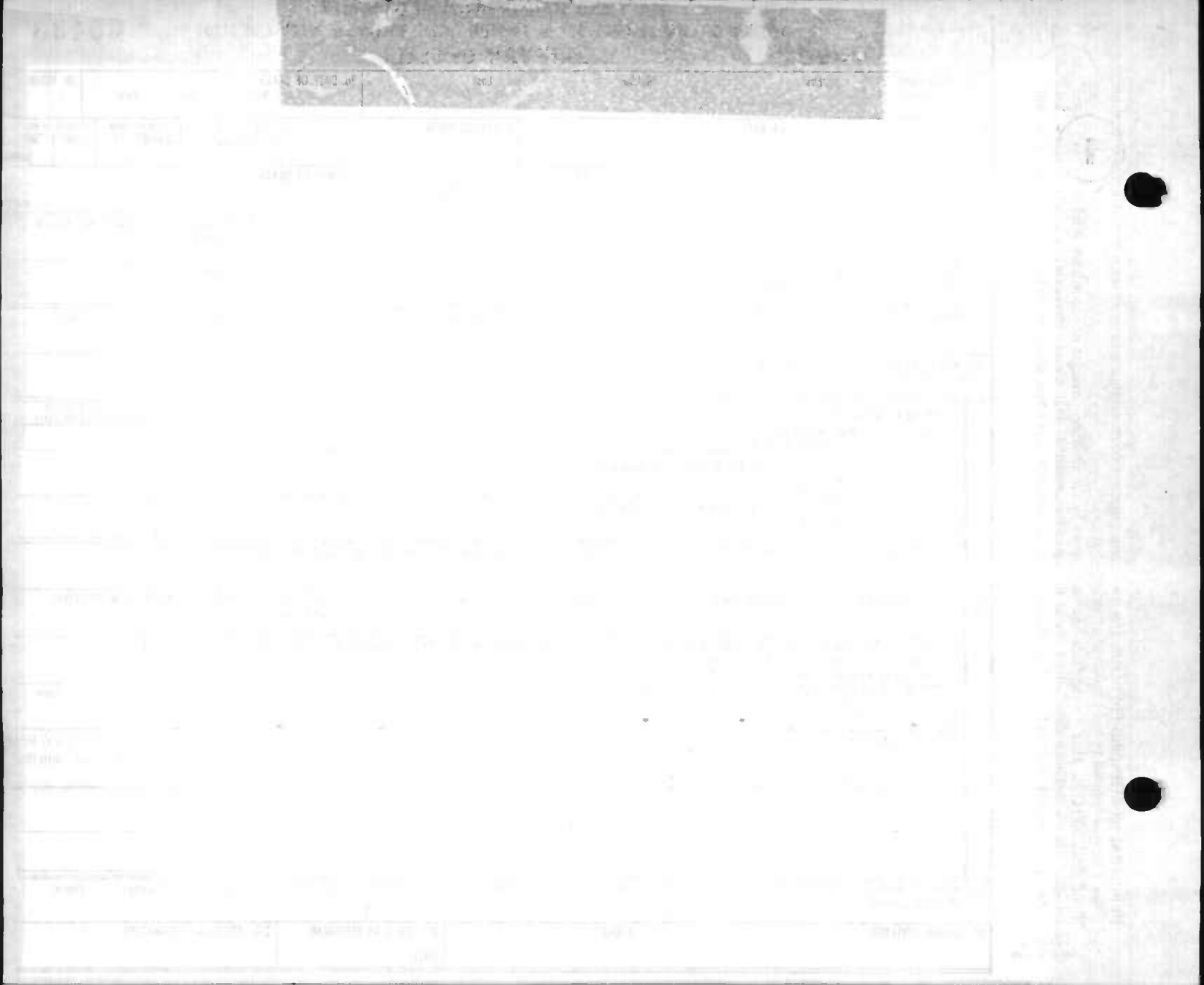
ADDRESS

6010 REISTERSTOWN ROAD, BALT 21215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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ACTION





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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|   |                     |  |   |
|---|---------------------|--|---|
| 05432   |                     | 05434  |   |
| 1. DECEASED-NAME (Type or print) <b>CHRISTOPHER GUSTAV WOPPMAN</b>  |                     |  | 2a. DATE OF DEATH<br>Month <b>4</b> - Day <b>11</b> - Year <b>68</b>  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br><b>12-11-1885</b>  | 6. AGE (In years last birthday)<br><b>82</b> YRS.   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>6719 CAMPEFIELD RD.</b>   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>PLAYGROUND ATT.</b>   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br><b>MD.</b>   |                     | 13b. COUNTY<br><b>BALTO.</b>   | 13c. CITY OR TOWN<br><b>BALTO.</b>  |
| 14. FATHER'S NAME First Middle Last<br><b>LAWRENCE WOPPMAN</b>  |                     | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>EMMA VATER</b>  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br><b>No</b>   |                     | 16b. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>Ms. AUGUSTA CONNINGHAM</b>  |                     | Address<br><b>6719 CAMPEFIELD RD.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>C.V.A.</b><br><b>4120</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSCLEROTIC &amp; HYPERTENSIVE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CARDIO VASCULAR DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>443X</b>   |                     |  |   |
| 19a. DATE OF OPERATION  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |                     | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                     | 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |                     | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 19 58</b> to <b>Apr 11, 19 68</b> , that (I) (we) last saw the deceased alive on <b>Feb 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above <b>(I) (we) (did) (did not) view the body after death.</b>  |                     |  |   |
| 22b. SIGNATURE<br><b>Andrew Leniscava</b>   |                     | 22c. DATE SIGNED<br><b>4/13/68</b>   |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>ANDREW LENISCAVA</b>   |                     | 22e. ADDRESS<br><b>2607 E. BALTIMORE ST.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                     | 23b. DATE<br><b>4-15-68</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN CEM.</b>  |                     | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO., MD.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Walter Hill - 2334 Jefferson St.</b>   |                     | 25a. REC'D BY REGISTRAR<br><b>DATE APR 16 1968</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                     |  |   |

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EXTRACT OF THE

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*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

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MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

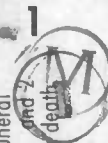
|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED-NAME (Type or print) First Middle Last<br><i>Bessie Zalis</i>  |   |   | 2a. DATE OF DEATH<br>April Month Day 24 Year 1968   |   | 2b. HOUR<br>12:45 P.M.                                     |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>White</i>   | 5. DATE OF BIRTH<br><i>FEB 3rd 1879</i>   |   | 6. AGE (In years lost birthday)<br><i>96</i> YRS.           | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Russia</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><i>BALTIMORE</i> Md.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>PIKESVILLE</i>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>MILFORD MANOR NURSING HOME</i> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>HOUSEWIFE</i>   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>AT HOME</i>   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>MARYLAND</i>   | 13b. COUNTY<br><i>BALTIMORE</i>   | 13c. CITY OR TOWN<br><i>BALTIMORE</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br><i>3951 W. NORTHERN PKWY. #15</i> |  |
| 14. FATHER'S NAME First Middle Last<br><i>SAMUEL FISHGOLD</i>  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>ZALATA ?</i>   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><i>NO</i>  | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT Address<br><i>MR. ALBERT VANN-ZALIS, 2938 BARTOL AVE. #9</i>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral + coronary occlusion</i><br><i>437.9</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____       |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>yo</i>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>334X</i>   |   |   |   |   |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1940</i> , 19____, to <i>4/24/68</i> , 19____, that (I) (we) last saw the deceased alive on <i>4/24/68</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death. |   |   |   |   |  |
| 22b. SIGNATURE<br><i>Milton B. Kirsh</i>   |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      | 22c. DATE SIGNED<br><i>4/24/68</i>  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>MILTON B. KIRSH</i>   |   | 22e. ADDRESS<br><i>4000 W. NORTHERN PKWY.</i>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>   | 23b. DATE<br><i>4-25-68</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>SHAAREI ZION</i>   | 23d. LOCATION (City or Town) (County) (State)<br><i>ROSEDALE, MARYLAND</i>                      |   |  |
| 24. FUNERAL DIRECTOR<br><i>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</i>  |   | 25a. REC'D BY REGISTRAR<br>DATE <i>APR 29 1968</i>  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |   |  |

2025 2024 2023 2022 2021 2020 2019 2018 2017 2016 2015 2014 2013 2012 2011 2010 2009 2008 2007 2006 2005 2004 2003 2002 2001 2000 1999 1998 1997 1996 1995 1994 1993 1992 1991 1990 1989 1988 1987 1986 1985 1984 1983 1982 1981 1980 1979 1978 1977 1976 1975 1974 1973 1972 1971 1970 1969 1968 1967 1966 1965 1964 1963 1962 1961 1960 1959 1958 1957 1956 1955 1954 1953 1952 1951 1950 1949 1948 1947 1946 1945 1944 1943 1942 1941 1940 1939 1938 1937 1936 1935 1934 1933 1932 1931 1930 1929 1928 1927 1926 1925 1924 1923 1922 1921 1920 1919 1918 1917 1916 1915 1914 1913 1912 1911 1910 1909 1908 1907 1906 1905 1904 1903 1902 1901 1900 1899 1898 1897 1896 1895 1894 1893 1892 1891 1890 1889 1888 1887 1886 1885 1884 1883 1882 1881 1880 1879 1878 1877 1876 1875 1874 1873 1872 1871 1870 1869 1868 1867 1866 1865 1864 1863 1862 1861 1860 1859 1858 1857 1856 1855 1854 1853 1852 1851 1850 1849 1848 1847 1846 1845 1844 1843 1842 1841 1840 1839 1838 1837 1836 1835 1834 1833 1832 1831 1830 1829 1828 1827 1826 1825 1824 1823 1822 1821 1820 1819 1818 1817 1816 1815 1814 1813 1812 1811 1810 1809 1808 1807 1806 1805 1804 1803 1802 1801 1800 1799 1798 1797 1796 1795 1794 1793 1792 1791 1790 1789 1788 1787 1786 1785 1784 1783 1782 1781 1780 1779 1778 1777 1776 1775 1774 1773 1772 1771 1770 1769 1768 1767 1766 1765 1764 1763 1762 1761 1760 1759 1758 1757 1756 1755 1754 1753 1752 1751 1750 1749 1748 1747 1746 1745 1744 1743 1742 1741 1740 1739 1738 1737 1736 1735 1734 1733 1732 1731 1730 1729 1728 1727 1726 1725 1724 1723 1722 1721 1720 1719 1718 1717 1716 1715 1714 1713 1712 1711 1710 1709 1708 1707 1706 1705 1704 1703 1702 1701 1700 1699 1698 1697 1696 1695 1694 1693 1692 1691 1690 1689 1688 1687 1686 1685 1684 1683 1682 1681 1680 1679 1678 1677 1676 1675 1674 1673 1672 1671 1670 1669 1668 1667 1666 1665 1664 1663 1662 1661 1660 1659 1658 1657 1656 1655 1654 1653 1652 1651 1650 1649 1648 1647 1646 1645 1644 1643 1642 1641 1640 1639 1638 1637 1636 1635 1634 1633 1632 1631 1630 1629 1628 1627 1626 1625 1624 1623 1622 1621 1620 1619 1618 1617 1616 1615 1614 1613 1612 1611 1610 1609 1608 1607 1606 1605 1604 1603 1602 1601 1600 1599 1598 1597 1596 1595 1594 1593 1592 1591 1590 1589 1588 1587 1586 1585 1584 1583 1582 1581 1580 1579 1578 1577 1576 1575 1574 1573 1572 1571 1570 1569 1568 1567 1566 1565 1564 1563 1562 1561 1560 1559 1558 1557 1556 1555 1554 1553 1552 1551 1550 1549 1548 1547 1546 1545 1544 1543 1542 1541 1540 1539 1538 1537 1536 1535 1534 1533 1532 1531 1530 1529 1528 1527 1526 1525 1524 1523 1522 1521 1520 1519 1518 1517 1516 1515 1514 1513 1512 1511 1510 1509 1508 1507 1506 1505 1504 1503 1502 1501 1500 1499 1498 1497 1496 1495 1494 1493 1492 1491 1490 1489 1488 1487 1486 1485 1484 1483 1482 1481 1480 1479 1478 1477 1476 1475 1474 1473 1472 1471 1470 1469 1468 1467 1466 1465 1464 1463 1462 1461 1460 1459 1458 1457 1456 1455 1454 1453 1452 1451 1450 1449 1448 1447 1446 1445 1444 1443 1442 1441 1440 1439 1438 1437 1436 1435 1434 1433 1432 1431 1430 1429 1428 1427 1426 1425 1424 1423 1422 1421 1420 1419 1418 1417 1416 1415 1414 1413 1412 1411 1410 1409 1408 1407 1406 1405 1404 1403 1402 1401 1400 1399 1398 1397 1396 1395 1394 1393 1392 1391 1390 1389 1388 1387 1386 1385 1384 1383 1382 1381 1380 1379 1378 1377 1376 1375 1374 1373 1372 1371 1370 1369 1368 1367 1366 1365 1364 1363 1362 1361 1360 1359 1358 1357 1356 1355 1354 1353 1352 1351 1350 1349 1348 1347 1346 1345 1344 1343 1342 1341 1340 1339 1338 1337 1336 1335 1334 1333 1332 1331 1330 1329 1328 1327 1326 1325 1324 1323 1322 1321 1320 1319 1318 1317 1316 1315 1314 1313 1312 1311 1310 1309 1308 1307 1306 1305 1304 1303 1302 1301 1300 1299 1298 1297 1296 1295 1294 1293 1292 1291 1290 1289 1288 1287 1286 1285 1284 1283 1282 1281 1280 1279 1278 1277 1276 1275 1274 1273 1272 1271 1270 1269 1268 1267 1266 1265 1264 1263 1262 1261 1260 1259 1258 1257 1256 1255 1254 1253 1252 1251 1250 1249 1248 1247 1246 1245 1244 1243 1242 1241 1240 1239 1238 1237 1236 1235 1234 1233 1232 1231 1230 1229 1228 1227 1226 1225 1224 1223 1222 1221 1220 1219 1218 1217 1216 1215 1214 1213 1212 1211 1210 1209 1208 1207

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |   |   |  |   |  |
|---|--|--|---|--|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |   |   |  |   |  |
| CERTIFICATE OF DEATH  |  |  |   |  |   |   |  |   |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>William Albert Zepp   |  |  |   |  | 2a. DATE OF DEATH<br>4 Month 22 Day 68 Year                                       |   |  | 2b. HOUR<br>10:20 AM                                    |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>Feb. 25, 1883  |   | 6. AGE (In years last birthday)<br>85 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                     |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Summit Nursing Home |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Farmer |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>FARM               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  | 13b. COUNTY<br>Howard  |   | 13c. CITY OR TOWN<br>SYkesville  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  | 13e. STREET AND NUMBER<br>Route 32                      |  |
| 14. FATHER'S NAME First Middle Last<br>William - Zepp   |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Lucille - Arrington  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)<br>No  |  |  |   | 16b. SOCIAL SECURITY NO.<br>?  |   | 17. INFORMANT Address<br>Mr. Wilbur Zepp, SYkesville, Md.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1) <u>Acute Coronary Thrombosis</u><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4/22/68 |  |  |   |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>4201   |  |  |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/16/68, 19__, to 4/22/68, 19__, that (I) (we) last saw the deceased alive on 4/19/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br>B. Martin Middleton M.D.  |  |  |   |  | 22c. DATE SIGNED<br>4/22/68   |   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>B. MARTIN Middleton   |  |  |   |  | 22e. ADDRESS<br>Catonsville, Md.  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>4-25-68   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. View Cemetery  |   | 23d. LOCATION (City or Town) (County) (State)<br>Howard Co. Md.                                   |  |   |  |
| 24. FUNERAL DIRECTOR<br>Harry W. Waight   |  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE<br>APR 25 1968                                    |   | 25b. REGISTRAR'S SIGNATURE<br>J. Charles Judge                       |   |  |

1823

STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-1 (A)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) <b>GEORGE FRANK ZIELINSKI, SR.</b>   |  | First Middle Last   |  | 2a. DATE OF DEATH<br><b>April 14, 1968</b>  |  | 2b. HOUR<br><b>4:25 PM</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>Dec. 1, 1889</b>   |  | 6. AGE (In years last birthday)<br><b>78</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Balto. Co., Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Middle River</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Myrtle Convalescent Home</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Farmer</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Chase</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>Eastern Ave. &amp; Brinkman Rd.</b>  |  | 13f. RURAL<br><b>Rural</b>  |  | 14. FATHER'S NAME First Middle Last<br><b>Jacob Zielinski</b>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Katherine ?</b>                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219 36 2242</b>  |  | 17. INFORMANT<br><b>Andrew Zielinski</b>  |  | Address<br><b>Same</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic carcinoma</b><br><b>151.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>gastric carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>151.8</b>  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                    |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January, 1966</b> , to <b>April 14, 1968</b> , that (I) <del>(we)</del> saw the deceased alive on <b>April 6, 1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <b>(did)</b> (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>See SE MD</b>  |  |   |  |   |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Samuel Stern, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>Fuller Medical Group Ridge Rd. Balto. 6</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/18/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Co., Md.</b>                      |  |
| 24. FUNERAL DIRECTOR<br><b>Brudzinski Funeral Home 1407 Eastern Ave.</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 16 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jones</b>  |  |

10423

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |  |  |   |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>WILLIAM</b>   |  | First <b>J.</b>  |  | Middle <b>ZOELLER</b>   |  | Last  |  | 2a. DATE OF DEATH<br><b>APRIL</b> Month <b>5</b> Day <b>1968</b> Year |  | 2b. HOUR<br><b>10:05</b> P.M.                    |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>3/25/1899</b>  |  | 6. AGE (In years last birthday)<br><b>69</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                      |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |   |  | Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Crane Maintenance</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Armco Co.</b>   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>8216 North View Rd. 21222</b>            |  |  |  |
| 14. FATHER'S NAME<br><b>Francis V.</b>   |  | First <b>Zoeller</b>   |  | Middle <b>Lydia</b>   |  | Last <b>E. Duffy</b>  |  | 15. MOTHER'S MAIDEN NAME<br><b>Lydia E. Duffy</b>                     |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br><b>Yes</b>  |  | (If yes give war or dates of service)<br><b>WW I</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-07-4168</b>  |  | 17. INFORMANT (Son)<br><b>Mr. Joseph D. Zoeller,</b>  |  | Address<br><b>46 Brockett St.</b>                                     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4201</b>   |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. _____ Month _____ Day _____ Year <b>19</b><br>P.M. _____                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                               |  | 21f. LOCATION Street or R.F.D. No. _____  |  | City or Town _____  |  | County _____  |  | State _____                                      |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 24, 1968</b> , to <b>April 5, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 5, 1968</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Jose Nepomuceno</b>   |  | DEGREE <b>M.D.</b>   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>April 5, 1968</b>  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Jose Nepomuceno, M.D.</b>   |  | 22e. ADDRESS<br><b>7620 York Rd. Towson, 21204, Md.</b>  |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/8/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                          |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 10 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |  |  |  |

